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NEW JERSEY MEDICINE

January 1992

THE JOURNAL OF THE MEDICAL SOCIETY OF NEW JERSEY



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SPECIAL ISSUE: HOME HEALTH CARE

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Newswatch

AMA DELEGATES ISSUE REPORT ON RBRVS...

Following an active House of Delegates meeting in December 1991, the American Medical Association (AMA) responded to concerns of the Medical Society of New Jersey (MSNJ) and other component societies by issuing a report on resource-based relative value scales (RBRVS). "The AMA has just begun to fight," declared James S. Todd, MD, executive vice-president. One of AMA's actions is an intensification of efforts to permit balance billing under Medicare through a sliding fee scale geared to patients' incomes. The AMA also is seeking a restoration of payments for EKG interpretation, elimination of fee reductions, and increased payment for assistants at surgery. Besides restoration of most of the originally proposed RBRVS cuts, the AMA won a "grace period" permitting physicians to submit claims for January 1992 using the old CPT visit codes.

PAs GAIN SUPPORT...

On December 16, 1991, legislation to authorize the use of physician assistants passed the Senate and was reported out of committee in the Assembly. S-3510 is being opposed by MSNJ and an Assembly vote is expected on or about January 6, 1992. Please contact your assemblymen.

NURSE PRACTITIONERS ON THE HORIZON...

Consistent with the administration's designs to allow limited licensees to practice medicine, S-3491, which authorizes nurses to prescribe drugs, diagnose, and treat diseases, also is ready to be voted on in the Assembly. Please contact your assemblymen and request a "no" vote.

OPTOMETRISTS TO PRESCRIBE...

Once again, the Legislature is considering a bill to permit optometrists to prescribe drugs. This legislation, S-3539, is even more perverse than the above bills since optometrists do not function under the direction of physicians.

MIIX WILL OFFER FREE INCOME PROTECTION COVERAGE FOR DOCTORS WHO BECOME HIV POSITIVE...

Effective January 1, 1992, the Medical Inter-Insurance Exchange (MIIX) will provide an HIV endorsement as an addition to its professional liability insurance coverage at no cost to New Jersey physicians. Doctors diagnosed as HIV positive will receive a benefit of $500,000 payable monthly over five years at $100,000 per year.

January 1992

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THE JOURNAL OF THE MEDICAL SOCIETY OF NEW JERSEY

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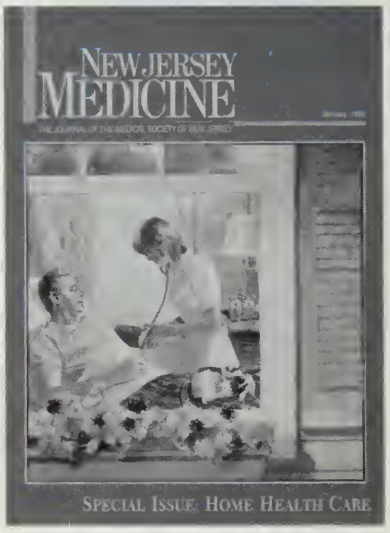
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The Cover

Developments in home care will return many aspects of patient care to the home setting. Our special issue begins on page 27. Cover: Williams & Philips.

Clinical Homecare

JCAHO ACCREDITED

MOVE UP TO THE NEXT LEVEL IN HOME INFUSION THERAPY: *Clinical Homecare's Physician Network*

Clinical Homecare has already established itself as one of the leading providers of homecare services in New Jersey. Our reputation is based on our pioneering home parenteral program of the early 1980s. Now, with the development of *Clinical Homecare's Physician Network*, we have achieved another major advance in the field of home infusion therapy.

Clinical Homecare's Physician Network builds on our existing physician directed homecare system. We have applied the familiar triangle of patient care, clinical research, and medical education to home infusion therapy. The Network creates in effect a "defacto" medical staff environment for physicians to communicate with each other regarding aspects of homecare and maximization of patients' therapy.

Joining Clinical Homecare's Network of premier physicians will provide member physicians with the following:

- ❒ Ongoing communications with fellow physicians
- ❒ Opportunities for consultation and collaboration
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- ❒ Assistance in facilitating reimbursements

Clinical Homecare hopes you will join with us in this exciting new endeavor, the Physician Network. To become part of the Clinical Homecare Physician Network, please call our Medical Department at

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As part of Clinical Homecare's ongoing commitment to home health care, we are pleased to have had the opportunity to assist New Jersey Medicine with its special issue.

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MSNJ NEWSLETTER

ADVANCE DIRECTIVES

New Jersey's law on advance directives took effect on January 7, 1992. Many people are seeking assistance in developing living wills and health care proxy representation. To obtain a booklet with explanations and recommended forms, physicians and laypersons may send a request to the state Bioethics Commission, CN 061, Trenton, NJ 08625, with $1 postage on an enclosed, self-addressed 9″ by 12″ envelope.

PREPAID HEALTH PLANS

The Division of Medical Assistance and Health Services has submitted a proposal concerning prepaid health plans that will appear in a future issue of *New Jersey Register.*

A prepaid health plan (PHP) can be a health maintenance organization (HMO).

The proposal is intended to replace the text located in the New Jersey Administrative Code at *N.J.A.C. 10:49-10.*

The basic provisions regarding recipient eligibility and enrollment remain the same.

The primary purpose of the proposal was to incorporate changes in federal law or regulations into New Jersey's Medicaid regulations.

One change is the requirement regarding contract sanctions. The types of activities that are subject to sanction include, but are not limited to, failure to provide medically needed services, imposing a premium on enrollees in excess of the amount permitted by law, discrimination among enrollees based upon health status, and falsifying information.

The penalties include warning(s), suspension, withholding of capitation payments, and/or termination of the contract.

The Division is required to give written notice if sanctions are imposed. The sanctions and penalties in the two preceding paragraphs are intended to be informational. The federal law, regulations, and state law and regulations, including the proposed material, provide the legal basis for the violations and resulting penalties.

There also is a provision pertaining to civil law concerning a "stop loss." This provision may be included in a risk contract. The intent is to limit the provider's liability if an enrollee were hospitalized.

WALLNER TO HEAD CANCER PROGRAMS

Paul Wallner, DO, a member of our Camden County component and chief of radiation oncology at Cooper Hospital/University Medical Center, has been elected president of the American Cancer Society, New Jersey Division. Earlier this fall, he was inducted as president of the American Cancer Society's Board of Directors.

As president, Dr. Wallner will act as the senior scientific spokesperson and representative for the American Cancer Society in New Jersey. He will be responsible for the activities of the Society's Medical Committee and Professional Education Committee.

Also, New Jersey Commissioner of Health Frances Dunston, MD, MPH, appointed Dr. Wallner as chairman of a task force charged with developing a cancer plan for New Jersey.

HISTORY OF MEDICINE COLLECTION

Morris H. Saffron, MD, a member of the Editorial Board of *NEW JERSEY MEDICINE* and the archivist of the Medical Society of New Jersey, has established a $25,000 book endowment in support of the historical medicine collection at the UMDNJ-George F. Smith Library of the Health Sciences. The Saffron Book Endowment will provide funds to acquire rare or important books in medical history. The new resources will be added to the collection established in 1978 when the Academy of Medicine of New Jersey presented its historical library to UMDNJ and named it in honor of Dr. Saffron as the "Morris H. Saffron Collection of Books on Historical Medicine."

DOWN'S SYNDROME: THE CHRONOLOGY AS LIFE GOES ON

The Association for Retarded Citizens and the Academy of Medicine of New Jersey have asked a consortium of health care providers to address the problem of trisomy 21 from a multidisciplinary approach. Physicians responsible for postnatal care may benefit by up-to-date knowledge regarding patient risk and prenatal diagnosis.

Speakers at this day-long program, devoted to the life of the patient with trisomy 21 from prenatal diagnosis to adulthood, will present talks on the following: risk screening of couples contemplating pregnancy; prenatal diagnostic screening and testing; in utero evaluation of the trisomy 21 fetus; care of the pregnancy complicated by trisomy 21; psychological ramifications of couples faced with diagnosis; newborn preparation and delivery precautions; care of the newborn with Down's syndrome; primary care of the child and adult with Down's syndrome; health, education, and human service system supports in New Jersey; and care of the aging person with Down's syndrome.

On Friday, April 3, 1992, the day-long symposium, including lunch, will be held at Morristown Memorial Hospital. On April 4, 1992, the agenda will include the same speakers in a Saturday morning format at Our Lady of Lourdes Medical Center, Camden.

The Academy of Medicine of New Jersey designates this continuing medical education activity for 4 hours in category I of the Physician's Recognition Award of the American Medical Association. For information and registration, please contact the Academy of Medicine of New Jersey, 1/609/896-1717.

HELPING SENIORS IN NEED

To assist Bergen County seniors who need help paying medical bills, the Bergen County Medical Society (BCMS) is offering a Medicare Assistance Program—MedCap. Charles M. Moss, MD, BCMS president-elect, said that participating physicians are accepting Medicare amounts as payment for eligible medical services for any Bergen County resident 65 years or older with an annual income of less than $20,475 ($25,125 for a couple). Individuals who do not meet these eligibility requirements, as set by the Bergen County Office of Aging, still can be considered for this program if a serious hardship exists. Patients pay only the $100 annual deductible and a 20 percent copayment as required by federal law, according to Dr. Moss.

"It's important that we, as the medical community, lend a helping hand to Bergen County seniors with limited incomes or who are experiencing a financial emergency," said Dr. Moss.

MedCap applications can be obtained by calling the New

Jersey Division of Aging at 1/201/646-2625. Seniors who are part of PAAD (Pharmaceutical Assistance Program for the Aged and Disabled) qualify automatically. The names of those who qualify will be submitted to BCMS, which will mail the MedCap cards with a letter of explanation. MedCap members must show the card during each visit and mention it when scheduling an appointment.

CLIA UPDATE

The revised rules to implement the Clinical Laboratory Improvement Act are being modified to the advantage of physician office laboratories (POLs). A new test complexity list as well as director and personnel requirements are less stringent than those published in May 1990. The testing levels have undergone major changes. The waiver list is shorter, but the level I (moderate complexity) list has been substantially expanded to include the majority of tests being performed in the office. The level II list (high complexity) still includes any test not found in the lower levels. Personnel standards also have been modified. The director of a level I laboratory can be a licensed MD or DO with one year supervising nonwaived tests or have had laboratory training during residency equivalent to the director's scope of responsibility. The waiver level and level I requirements for employees doing testing (testing personnel) is a high school diploma or equivalent with documented training similar to technical knowledge. It is recommended that the laboratory have a technical or clinical consultant in offices that have laboratory personnel with minimal laboratory training. If a laboratory has a registered medical technologist on staff, the technologist may fulfill this function.

In level II (high complexity) laboratories, an MD or DO may direct his own laboratory by showing documented proof of two years' training or experience directing or performing high complexity tests. Maintaining an office laboratory would be considered experience. A clinical or technical consultant is recommended at this level. An associate degree in laboratory science or medical laboratory technology is the minimum requirement for the general supervisor and/or testing personnel. A testing assistant working under the testing supervision of the general supervisor must meet the same qualifications as the testing personnel in level I. A specific description of personnel and director requirements is outlined in the final regulations.

Proficiency testing requirements and enforcement are undergoing changes. The challenges will be greater in specimen number but only sent out three times a year. Proficiency testing companies cannot meet the immediate POL need for 1992 enrollment and POLs not presently in such programs will have to be phased in.

BIBLIOPHILIA AND MEDICAL HISTORY

The theme of the Annual Meeting of the Medical History Society of New Jersey (MHSNJ) is bibliophilia and medical history. The program will include three papers, two talks on experiences of book collectors and book sellers, and displays and poster sessions by collectors and booksellers. The keynote speaker is W. Bruce Fye, MD, from the Marshfield Clinic, Wisconsin.

The Annual Meeting of MHSNJ will be held on May 19, 1992, at the Nassau Club in Princeton. For further information on this meeting or to obtain an application for membership to MHSNJ, please contact the Academy of Medicine of New Jersey, 1/609/896-1717.

MIIX will offer free income protection coverage for doctors who become HIV positive.

Because we understand.

"We are addressing a problem which can have a potentially devastating impact on those few doctors who may be affected. We are here to serve doctors with responsive and innovative programs, and I believe that we are doing our part to deal straightforwardly and candidly with this dilemma for doctors and patients alike."

— Daniel Goldberg
MIIX President

The Medical Inter-Insurance Exchange is pleased to announce effective January 1, 1992 its Human Immunodeficiency Virus (HIV) Insurance Endorsement as a no cost addition to its professional liability insurance policies for New Jersey doctors. Should you be diagnosed as HIV positive, the endorsement will provide you with a benefit of $500,000, payable monthly over 5 years at $100,000 per year.

For more information, please call Policyholder Services at 800-257-6288.



Medical Inter-Insurance Exchange
Two Princess Road • Lawrenceville, NJ 08648-2382

Questions and Answers on . . .

What does this coverage mean to me as an insured?

Our HIV insurance endorsement is an income protection coverage added to your professional liability policy. This coverage goes into effect for eligible insureds on January 1, 1992. This endorsement provides — at no additional cost— a benefit of $500,000, payable monthly over five years at $100,000 per year, in the event that you become HIV seropositive.

Why is MIIX offering this endorsement?

As a doctor-owned company, MIIX's mission is to serve the medical profession with responsive and innovative programs. The purpose of this coverage is to lessen the personal anguish of those few doctors who may become HIV seropositive by easing the potential financial impact on them and their families.

How do I become an eligible insured for this coverage today?

Doctors insured by MIIX for two or more policy years:

- Complete a one page application form. NO TEST IS REQUIRED.

Doctors insured by MIIX for less than two policy years or new applicants:

- Complete a one page application form and provide acceptable evidence that you are currently HIV seronegative.

What is the significance of the two-year insured eligibility requirement?

This is a customary preexisting condition clause common to insurance policies.

Does the coverage extend to the doctor's staff?

For the 1992 policy year, the coverage extends only to doctors. However, as experience accumulates, the coverage may be expanded to other groups.

Can this HIV coverage be purchased separately?

No. This endorsement is part of our professional liability policy and supports our approach to the issues of HIV/AIDS infection. This strategy includes, among other things, counseling from the Medical Society's Physicians' Health Program and an exclusion from professional liability coverage for any HIV-seropositive doctor who fails to take precautions as established by law or the Centers for Disease Control (CDC).

If your current professional liability carrier does not provide this added coverage, call MIIX now for details on how to change carriers and become immediately eligible for our HIV endorsement.



Medical Inter-Insurance Exchange
Two Princess Road • Lawrenceville, NJ 08648-2382

MIIX HIV Coverage

Is coverage for HIV available from other policies such as worker's compensation or disability?

MIIX is unable to answer this question since such policies vary as to when coverage becomes effective. Our endorsement is not intended to replace any of these other policies, but rather, to act as an income supplement. We encourage you, however, to raise this question with your other insurance carriers.

Are there any exclusions to this coverage?

This endorsement is intended to be comprehensive and cover any insured who tests HIV seropositive, regardless of source. However, these benefits are *not* provided if:

- An insured has received treatment and/or medical advice prior to the effective date of this endorsement for a physical condition or sickness symptomatic of being HIV seropositive.
- An insured is diagnosed HIV seropositive prior to the effective date of the endorsement.
- HIV is/was intentionally self-inflicted, or
- A fraudulent act is committed.

How are benefits paid?

Currently, benefits will be paid on a monthly basis over a five year period. In the future, however, we may change the benefit payout options depending on our claims experience and the needs of our insureds.

Do I have to contract AIDS or be physically disabled to receive the HIV coverage benefit?

No. The benefit is payable upon conclusive evidence that you have tested HIV seropositive. It is not necessary to demonstrate that you have developed AIDS or that you are physically disabled.

Will you require that doctors modify their practice in order to collect the benefit?

In order to receive the benefit, a doctor must agree to follow any and all state, federal or CDC regulations and guidelines concerning HIV practice protections. These guidelines are still being developed and may vary based on specialty.

Please call MIIX Policyholder Services at **800-257-6288** for further information.

PROFESSIONAL LIABILITY

MALPRACTICE VERDICTS

Patient Suicide. A psychiatrist was cleared by a jury in New Jersey of a malpractice claim that he improperly relied on findings of a psychiatric social worker and negligently failed to hospitalize the patient. Nine days after presenting to a hospital emergency department and being examined by the psychiatric social worker, the 59-year-old patient shot himself to death at home.

The plaintiff's claim was that the psychiatrist should have conducted his own examination, and that the social worker's notes documented the need for hospitalization. A defense expert testified that reliance on a psychiatric social worker's notes is common.

Neither the psychiatrist nor the social worker considered the patient suicidal. Apparently both were unaware that a suicide threat to his wife had prompted the patient's visit to the emergency department. Reasons for the patient's depression included a fear of being HIV positive, a brother's brain tumor, and the recent nursing home admission of his father.

Lung Biopsy. Another New Jersey jury brought in a verdict for a cardiologist accused of negligently proceeding with an open lung biopsy despite indications that the patient may have suffered an infarct two days earlier.

The patient, in his 60s, had been admitted with difficulty breathing, and a differential diagnosis of pneumonia was made. After continued deterioration and a negative bronchoscopy, the biopsy was performed. Two days later the patient died.

In defense, the cardiologist contended that respiratory difficulties posed a threat to life that justified the biopsy, notwithstanding the nonspecific cardiac event that occurred before the procedure. The defendent further questioned whether the cardiac event was indeed an infarct.

Lung Cancer Diagnosis. Also prevailing before a jury in the state was a team of internists who advised a patient against a chest x-ray during a routine physical examination. Ten months later the patient was diagnosed with lung cancer.

Previously, the patient was x-rayed on a biennial basis. His history included smoking for 30 years. In the interim, the American Cancer Society changed its guidelines to recommend against x-rays of asymptomatic individuals with a history of smoking on the grounds that x-rays would not help prolong life.

In charging the jury, the judge stated that, if the jury found that the defendants were negligent and that their negligence increased the risk of harm to the patient, the jury should estimate the percentage chance of survival based on a timely diagnosis. The finding of no negligence relieved the jury of having to make this estimate.

Paying and Suing. May a patient agree in small claims court to pay the physician's bill and then sue the physician for malpractice? Overruling a trial judge who granted a summary judgment for the defense, a panel of three judges in the Appellate Division said yes.

The defendant, a vascular surgeon, performed bilateral varicose vein ligation and stripping on a patient who complained of ulcers on his left leg. Increasingly dissatisfied with his postoperative progress, the patient eventually consulted another physician who allegedly advised that the surgeon's preoperative testing had been inadequate.

Later, the surgeon filed a complaint in the Special Civil Part seeking payment for his $1,275 bill. Unassisted by counsel, the patient replied that the bill had been submitted to his insurer. Eventually a settlement on the bill was reached, with the patient agreeing to pay the full unreimbursed amount of $160.80.

Citing the doctrine of entire controversy, the trial court ruled that the settlement precluded the patient from bringing the malpractice action to court in a separate proceeding. The doctrine is intended to promote efficiency by clustering related claims between the parties in a single proceeding.

The appeals court stated that the entire-controversy doctrine requires "as a matter of first principle, that the party whose claim is sought to be barred must have had a fair and reasonable opportunity to have fully litigated that claim in the original action. That first principle clearly was not met here." Added the court: "It would obviously be counterproductive in the extreme were a preclusionary rule enforced in such a way as to penalize . . . a pro se litigant's participation in the small claims mediation process."

Informed Consent. Pennsylvania's Superior Court has affirmed a judgment for an orthopedic surgeon who performed two unplanned procedures during surgery. A decompression laminectomy and possible spinal fusion were planned for the surgery, which was conducted

due to continued discomfort following a laminectomy that the surgeon performed almost four months earlier.

During the surgery, while the patient was under anesthesia, the surgeon encountered significant scar tissue adhering to the dura. He consequently performed an intradural removal of the adhesions and an intradural injection of Depo-Medrol®. The plaintiff's claim was that the patient did not consent to these additional procedures.

The Court noted that this was not a case where exploratory surgery was translated into corrective surgery. The added procedures, concluded the Court, may have been necessary to protect the patient's health.

Employment Review. A physician under contract to review records of pre-employment physical examinations for the United States Postal Service escaped liability for reporting that an applicant suffered from a personality disorder. The physical examination, performed on a former employee seeking reinstatement, disclosed a back injury. The applicant claimed that the finding of a disorder was based on conversations with the physician's secretary when the applicant was seeking an end to delays in processing her application. To the Supreme Court of Appeals of West Virginia, the legal action was in the nature of defamation of character, not malpractice—but the statute of limitations on defamation had expired.

MALPRACTICE POLICY DEVELOPMENTS

Caps on Damages. Ohio's Supreme Court has struck down a $200,000 statutory cap on noneconomic damages. The Court found that the cap violated the state constitution's due process clause because there was no evident relationship between the means (a cap) and the end (containing malpractice premium rates). The Court was impressed by reports showing that large damage awards are rare and do not substantially reduce overall malpractice costs.

Additionally, the Ohio Supreme Court noted that, unlike certain other states, Ohio in its 1975 law did not link the cap to creation of an insurance fund providing plaintiffs with a source of relief. Although the cap violated due process, said the Court, the cap did not violate rights of equal protection. And, the Court upheld a collateral source provision of the law that limited certain types of double recovery.

The case involved a jury verdict for damages only. The jury found damages of $845,000 for pain and suffering and $126,000 for loss of consortium for a patient who was paralyzed from the neck down after surgery to repair a neck fracture sustained in an automobile accident. The cap would have reduced the award by $771,000.

Cap on Damages II. However, the Fifth U.S. Circuit Court of Appeals upheld Louisiana's $500,000 malpractice cap and applied it to a case in which the federal government was the defendant. In a trial before a judge without a jury, damages of $3.9 million were awarded for the failure of physicians at a military hospital to diagnose a dermoid cyst on the lower back of the plaintiff's daughter on a timely basis.

Earlier, the same Court applied Texas's malpractice cap to the government. And, the Ninth U.S. Circuit Court of Appeals has upheld California's cap. The constitutionality of the Louisiana cap had not been fully determined previously, although the state Supreme Court had upheld the cap.

Louisiana's cap is tied to a patient compensation fund. The fund reimburses damages between $100,000 and $500,000. Because the government does not contribute to the fund, the government agreed to pay $500,000 to the plaintiffs, rather than only the first $100,000. With this adjustment, the appeals court found that the government met the burden of the federal Tort Claims Act: "The United States shall be liable . . . in the same manner and to the same extent as a private individual under like circumstances. . ."

Tort Reform. Readers may wish to be alert for developments involving tort reform in New Jersey. This may prove to be a fertile area for cooperation among Governor Jim Florio, the newly elected Republican-dominated Legislature, and advocacy groups including the Medical Society of New Jersey.

MEDICARE PAYMENT

Medicare Economic Index. A new Medicare Economic Index (MEI) is being established by the federal Health Care Financing Administration (HCFA) for the first time since 1975. The Index will be used to set aggregate increases in physician reimbursement beginning in 1992 and to make annual changes in payment conversion factors. The MEI was discussed in an article published in *Health Care Financing Review.*

A series of changes alter the weights assigned to the various factors that are analyzed in making annual adjustments. Out of a total weight of 100 percent, the current and proposed weights for selected expense categories are shown in the Table.

In another change, these weights would shift from year to year, based on relative price changes. To make these adjustments, HCFA is adopting the Laspeyres Price Index, described as "a fixed-weight Index because it answers the question of how much more it would cost at a later

Table. *Current and proposed weights.*

Expense Category	Current Weight (Percent)	Proposed Weight (Percent)
Physician time (earnings)	60.0	54.2
Nonphysician compensation	18.8	16.3
Office expenses	9.2	10.3
Medical materials and supplies	3.6	5.3
Malpractice premiums	4.0	4.8
Medical equipment, automobile, and other	4.4	9.1

time to purchase the same mix of goods and services that was purchased in the base period."

The most important factor, physician time, will continue to be calculated based on overall incomes, not just physician incomes. In this factor, physicians do not benefit from overall increases in productivity throughout the economy, because physicians can benefit directly from increases in their own productivity by raising their volume of office visits or procedures.

On average, say the authors, during the years 1982 to 1990 and, as forecast, 1991 to 1995, the current MEI amounts to a 3.7 percent annual increase, compared to an average increase under the new MEI of 3.8 percent.

Joint Ventures. As noted in these pages last month, a Department of Health and Human Services Appeals Board has overturned a ruling that physicians may refer patients to a facility they own so long as their ownership is not based on an "agreement to refer."

In *The Inspector General v. The Hanlester Network, et al.*, the Appeals Board of September 18, 1991, held that the federal anti-kickback statute is violated "whenever an individual or entity knowingly and willfully offers or pays anything of value, in any manner or form, with the intent of exercising influence over a physician's reason or judgment in an effort to cause the referral of program-related business." Such violations occur even if the payment is indirect, stated the board. The case was remanded to the administrative law judge to determine whether the physician-owned laboratories were so intending to influence referrals.

RIGHT TO DIE WITH DIGNITY

Ombudsman Regulation. The Appellate Division of New Jersey's Superior Court has upheld regulations of the state Ombudsman for the Institutionalized Elderly that permit nursing homes to withhold life-sustaining treatment. The regulations state that withholding treatment in accordance with statute does not constitute patient "abuse."

In the Court's view, "the Ombudsman had the clear authority, indeed the obligation, to define abuse to include, in certain circumstances, providing life-sustaining treatment and to exclude, in certain circumstances, withholding or withdrawing life-sustaining treatment."

However, the court ordered the Ombudsman—who inspects nursing homes to protect against patient abuse—to change one facet of the new regulations. This change requires two physicians, not just the attending physician, to determine whether the patient is competent to make decisions about treatment.

American Medical Association (AMA) Brief. Parents of an incompetent patient do not lose their right to make medical decisions for the patient when the patient attains the age of majority, the AMA has argued in an amicus curiae brief submitted to the Supreme Court of Missouri. The case arises in the same state that spawned the *Cruzan* case decided by the U.S. Supreme Court in 1990.

Christine Busalacchi is incompetent and apparently in a persistent vegetative state. Her father seeks to move her to a state with more liberal right-to-die laws. The AMA brief, submitted in conjunction with the Missouri State Medical Association, contends that the lower Court erred in saying that courts, rather than the patient's father, should determine what is in the patient's best interests.

Missouri parents have the duty under state law to support infirm adult children and, therefore, have the right to make decisions on behalf of such children, argues the AMA. In addition, the brief asserts that the lower Court decision, by creating two classes of parents separated by whether their child has reached age 18, violates the equal protection clause of the Constitution. The age of majority exists to protect the rights of children and relieve parents of their duty of support, adds the brief, and neither purpose is served by the lower Court's distinction.

MALPRACTICE TIPS

Fee Disputes. A monthly "Loss Minimizer" insert to the *Medical Liability Monitor* cautions physicians against generating fee disputes with patients: "Disputes about fees charged and about collection of unpaid fees, particularly if the outcome of medical care was not optimal, are catalysts for malpractice suits."

The publication's suggestions include: inform patients about basic fees and forseeable charges; provide new patients with written information on basic fees, and with a patient information brochure or "welcome to our pratice" letter; supply patients with the name and telephone number of a contact person on payment issues; and obtain and pass on to patients information about fees charged by referral specialists.

Geriatric Trauma. The elderly account for approximately one-fourth of trauma fatalities. Elderly trauma victims are extremely intolerant of head injuries and shock and, therefore, require careful monitoring for signs of shock and frequent neurologic evaluations.

Chest injuries also are dangerous, due to older patient's decreased pulmonary and immunologic reserves.

Fluids should be administered initially only in one or two liter amounts. Tension pneumothorax, myocardial contusion, and pericardial tamponade must be considered before too much fluid is administered.

Falls sustained by the elderly often are a symptom of a disease process, such as cardiac dysrhythmias, epilepsy, and electrolyte imbalance. Vision impairments, loss of coordination, and effects of medications also may be implicated.

These tips come from *Personal Injury Newsletter,* November 4, 1991.

Head Trauma. On October 21, 1991, *Personal Injury Newsletter* addressed the topic of nutritional support for head trauma patients: "Patients with severe head injuries often become hypermetabolic and hypercatabolic as a result of their inability to eat." Nutrition support can improve clinical outcomes, although complications such as aspiration pneumonia may result. Intracranial pressure may reduce gastric motility and, thus, account for poor tolerance to gastric feedings during the first week of treatment.

AIDS ISSUES

Physician and Nurse Attitudes. Columbia University's School of Public Health has generated preliminary results of a federally funded survey of physician and nurse attitudes involving AIDS. Health professionals in 25 states were surveyed between July 1990 and January 1991.

Consider these findings:

Approximately three-fourths of the physicians and nurses favored mandatory HIV testing of surgical patients and pregnant women; about three-fifths of physicians and nurses favored mandatory testing of health professionals; and about one-half of physicians and nurses supported mandatory testing of all hospital patients.

Only about one-half of the surgeons would operate on an asymptomatic HIV-positive patient. Sixty-four percent of physicians and 29 percent of nurses feel that they have a substantial amount of choice about caring for HIV-positive patients. Majorities in both professions, especially nursing, view themselves as professionally "obligated" to provide such care. About one-third of the members of each profession expressed fears about acquiring HIV through occupational exposure.

Perhaps the real story in the results involves universal precautions. Physicians and nurses are each about twice as likely to wear gloves if the patient is known to be seropositive. If the serostatus is unknown, only 42 percent of physicians and 59 percent of nurses wear gloves. For such "unknown" patients, only 7 percent of physicians wear double gloves, 4 percent of physicians wear gowns, and 4 percent of physicians wear masks.

The preliminary report was issued by the Agency for Health Care Policy and Research, part of the U.S. Public Health Service.

Needle Exchanges. Free needle exchanges may offer a way to reduce HIV transmission among intravenous drug users, while also providing a forum for one-on-one AIDS education of people at high risk. In Jersey City on November 8, 1991, in a bench trial, Muncipal Judge Allan Horowitz acquitted four AIDS activists of possession of hypodermic needles and narcotics paraphernalia. The four apparently had intended to distribute the materials outside a methadone clinic.

The defense, conducted by an American Civil Liberties Union lawyer, focused on the defendants' lack of criminal intent. Defense experts included a member of the National Commission on AIDS and a social worker involved in AIDS education at UMDNJ.

Judge Horowitz stated that the acquittal is based on a single set of facts, and he cautioned against seeing it as a legal or social precedent. But, he agreed with the defense that sometimes it is necessary to violate the law in order to prevent greater harm.

Needle exchanges are opposed by New Jersey Health Commissioner Frances Dunston, MD. A demonstration program was just approved by New York City Mayor David Dinkins.

SCIENCE AND MEDICINE

Was Nazi medicine an aberration or the natural product of the intrusion of politics into medicine? And, if the former, does German reunification threaten to promote flaws in the German character?

These questions are explored in a book review in the *Journal of Health Politics, Policy and Law.* The book by Robert N. Proctor, (*Racial Hygiene: Medicine Under the Nazis,* Cambridge, MA, Harvard University Press, 1988) explores currents underlying deadly and cruel experiments on Jewish and gypsy newborns and other horrors. The author asserts that science, never pure, reflected in German doctrines of Social Darwinism and Nazism.

Reviewer David Rosner commented: "As one reads the book, one can't help thinking of the genome project or of more current debates in the United States over supposed differences in intelligence without a tremendous degree of anxiety." Mr. Proctor's message that racism all too easily cloaks itself in the objective language of science is chilling.

ADVERTISING

FTC Order. The AMA has won relief from some of the enforcement provisions of a 1982 final order prohibiting limits on physician advertising. On October 11, 1991, the Federal Trade Commission (FTC) modified the order to free the AMA from having to disaffiliate medical societies that restrict truthful, nondeceptive advertising.

Under the modification, the state societies and 250 of the largest county societies must either adopt an FTC-approved resolution permitting advertising or else obtain AMA legal review of their advertising policies. The AMA attorneys will report violations of the antitrust laws and assist the societies to come into compliance. Societies representing at least two-fifths of all society members must obtain the AMA review in order for the AMA to be deemed in compliance.

FTC Commissioner Mary L. Azcuenaga "emphatically" dissented from the modification. "In effect," declared Ms. Azcuenaga, "the Commission appoints the AMA guardian of the proverbial chicken coop despite its years of defying the [original] order."

Hotline. Another federal agency regulating health care communications, the Food and Drug Administration, has set up a toll-free hotline to answer questions about its policies on medical advertising, marketing, and promotion. The policies affect pharmaceutical manufacturers' gifts to physicians and support of continuing medical education (CME), which are being closely circumscribed by the AMA and by CME accreditation organizations. The number is 1/800/238-7332. That's AD-US-FDA (or, if you prefer, BETSEE-B).

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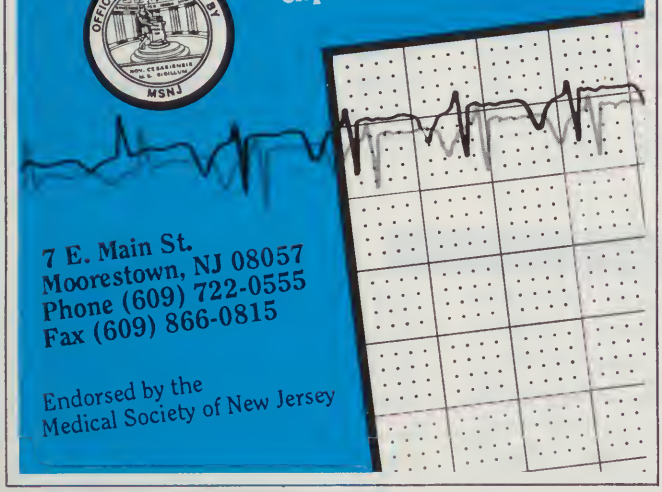
Authors of this monthly commentary are James E. George, MD, JD, and Neil E. Weisfeld, JD, MSHyg, of MSNJ's Department of Professional Liability Control.

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Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalmic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

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Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.[1,3,4] 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to ½ tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.[3]

How Supplied: Oral tablets of Yocon® 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

References:

1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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BOOK REVIEWS

NEW DIMENSIONS IN AEROBIC FITNESS

Brian J. Sharkey, PhD. Champaign, IL, Human Kinetics Books, 1991. This monograph is aimed at the exercise physiologist doing research in the field of physical fitness. However, there are several chapters that would be of equal interest to physicians, particularly cardiologists, interested in the benefits of exercise in the rehabilitation of their cardiac patients.

The chapter on aerobic fitness and health covers the benefits and risks associated with exercise programs, and details research in the field.

The monograph is well written and easy to read. I recommend it to any physician, for his own health as well as the health of his patients. ☐ Christine E. Haycock, MD

ONE-MINUTE ASTHMA

This is a 32-page pamphlet focusing on what parents need to know regarding asthma. Dr. Plaut also is the author of *Children with Asthma.* Contents of this small pamphlet, "One-Minute Asthma," are evenly distributed in three parts. The first part discusses the basics of asthma. The second part is dedicated to adrenaline-like medications, such as theophylline, cromolyn, and steroids (oral and inhaled). The last section is devoted to devices including peak flow meters, the use of inhalers, chambers, and nebulizers. There is a short, two-page section on resources that is limited to the author's personal contribution and certainly is not extensive. This pamphlet should make a good handout for physicians in the education of their asthmatic patients. ☐ Leonard Bielory, MD

PRECONCEPTION CARE OF MEN AND WOMEN

Margaret Wynn; Arthur Wynn. London, England, A B Academic Publishers, 1991. Considerable data now exist regarding health integrity and the outcome of pregnancy. Many factors influence the complex events surrounding conception and much evidence suggests that certain interventions may enhance the chances of having a healthy baby.

Some hazards clearly jeopardize fetal health. One such hazard, too-close birthspacing, appears to increase the risk of congenital malformations. Failure to conceive, miscarriage, prematurity, or birth of a stillborn or a handicapped infant may be influenced by events occurring prior to conception. How to recognize and deal with these problems are the subjects of this concise, comprehensive book, *The Case for Preconception Care of Men and Women.*

The authors, as social scientist and as environmental scientist, have investigated the world's literature and have jointly studied the evidence. In separate chapters, they consider susceptible periods in women predisposing to genetic mutation, congenital malformations caused by damage to sperm, the effect of diet and nutrition on reproduction, the influence of infectious illness, and that of premature aging.

Information contained in this book will be of considerable interest to obstetricians, family planning counselors, and those interested in eugenics. It is doubt-

ful that young couples anxious to start families would be willing to adopt such a scientific, calculating approach; nevertheless, considering how much can go wrong, it would be well if all of us paid closer attention to these matters. ☐ Alan J. Lippman, MD

PRINCIPLES OF CANCER BIOTHERAPY, 2ND EDITION

Robert K. Oldham (ed). New York, NY, Marcel Dekker, Inc., 1991. When the first edition of this text appeared in 1987, biotherapy—or the use of biological substances in the treatment of cancer—was virtually in its infancy. Considerable doubt existed regarding the potential therapeutic value of the new approaches offered by biopharmaceuticals. In five short years, however, sufficient maturity has brought about the need for this thoroughly updated second edition providing ample insight into what now is regarded as the fourth modality of cancer treatment.

Based on the principles of molecular biology, biotherapy represents a rational approach to cancer treatment. Other modalities—surgery, radiation, and cytotoxic chemotherapy—depend upon destroying cancer cells by physical or chemical means. With biotherapy, specific molecular interactions provide novel opportunities for natural, biologic manipulation of cell growth, opening a new era that almost surely will lead to meaningful progress in the conquest of cancer.

The new edition, with 49 contributors and more than 3,800 current literature references, provides an indepth analysis of the substantial progress made in defining the roles of growth and differentiation factors, the use of synthetically derived molecular analogs, and the pharmacological exploitation of biological molecules. Among the 24 chapters, specific highlights include developmental therapeutics based upon recombinant technologies, cancer epitope vaccines, immunotoxins, drug immunoconjugates, biotherapy in bone marrow transplantation, colony-stimulating factors, oncogenes, anti-oncogenes, and growth factors.

As the editor and a pioneer in this field, Dr. Oldham speculates in the final chapter how biotherapy will impact on the science and practice of cancer medicine as the field evolves through the 1990s and beyond. He observes how some forms of cancer biotherapy provide new strategies for the control of cancer, such as "tumor stabilization" and control of cell growth and behavior over a period of time, not unlike the use of insulin in the treatment of diabetes. Finally, he calls attention to the extraordinary demands to be made on our medical care system as expensive new technologies are integrated into clinical management programs. ☐ Alan J. Lippman, MD

SURGICAL TEACHING: PRACTICE MAKES PERFECT

Neal Whitman, MD, and Peter Lawrence. Salt Lake City, UT, University of Utah School of Medicine, 1991. This small text represents both a philosophic and a didactic approach to surgical training and to teaching methodology. The chapters cover a variety of topics: the principles of adult learning, motivation techniques, improving lectures, and clinical teaching on the wards and in the operating room. The chapter on improving lectures is excellent, and would be useful for teaching any subject.

Surgical Teaching: Practice Makes Perfect is worth reading even by experienced professionals involved with medical students or residents. For the physician involved in the field, it is a book worth reading. ☐ Christine E. Haycock, MD

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LETTERS AND VIEWPOINTS

SEXUAL HARASSMENT

Sexual harassment in the workplace has been the subject intensively and exclusively studied by the Committee on Women of the New Jersey Psychiatric Association for the past three years. The Committee recognized the pattern of harassment Professor Anita Hill had suffered; how she handled it typified everything in our studies. We sent a statement to President Bush and to the senators on the Judiciary Committee, urging that the confirmation hearings of Judge Clarence Thomas be delayed until the allegations of Professor Hill be scrutinized.

We were pleased that the senatorial confirmation vote was delayed to include Professor Hill's testimony; maybe our statement helped. The hearings took place during Mental Health Awareness Week sponsored by the American Psychiatric Association; the theme of the week was "Silence is No Treatment." Our Committee was not silent, and it is regrettable that too many professional organizations were silent. The American Medical Association (AMA) remained silent, as did the psychoanalytic and therapist societies, the American Bar Association (ABA), and many women's and civic organizations.

During this time, eight psychiatrists across the nation stood ready to speak on this issue if called upon by the Senate Judiciary Committee or the media, to explain the consistency or inconsistency of Professor Hill's story, and to tell the nation what is the natural course of experiences for a victim of sexual harassment, from beginning to end—how few sexually harassed individuals ever come forward to document or report their experiences at all, and how traumatic memories now are known to be processed.

The president, the senators, and the American public had been allowed to maintain a delusion about sexual harassment, a false belief that coming forth hesitantly years after the experience and failing to document such experience renders the allegation invalid. It was not widely known that the president and the senators had agreed there would be no expert witnesses.

Elizabeth M. Schneider, a visiting professor at Harvard Law School, was quoted in *The New York Times* editorial section of October 13, 1991, in "Theater of Pain, A Terrible Wrong Has Been Done, But to Whom?" She said, "The senators will be evaluating that credibility in a total vacuum. We're dealing with people who do not understand the wealth of study that has been done on this issue."

Fortunately, the American Medical Women's Association (AMWA), the American Psychiatric Association (APA), and the Association of Women Psychiatrists (AWP), issued decisive statements describing typical sexual harassment. They took no position directly on the nomination of Judge Thomas or his comparative credibility. Instead, AMWA sought "to provide much-needed public education on the issue of sexual harassment," and the APA showed sexual harassment to be "destructive behavior that can cause profound psychiatric problems for its victims." AWP asked that attention be directed to "the trivialization and denial of harassment issues."

The AMA keeps recruiting women physicians into its ranks, but remained silent on a health issue that had almost every American family riveted to the television screen. And, despite the criticism in the media by individual lawyers about how poorly the hearings were conducted, the ABA has not yet had this issue on its agenda. If the AMA and ABA examined the ranks of women physicians and attorneys, they would find plenty of case material very relevant to these senatorial hearings.

When the president of the United States or his First Lady have thyroid disease or cancer, the media is full of graphic descriptions of the pathophysiology of the illness and statements from outstanding medical authorities and representatives of the medical and specialty societies. Can organized medicine and law develop a mechanism, on an emergency basis, to address a significant issue that commands the attention of the nation and the world, as just happened?

Can the AMA, the ABA, and our own state medical and legal societies, and other mental health associations stand up to be counted, while the count is still on? □ Rita R. Newman, MD, Fellow, American Psychiatric Association; Chair, Committee on Human Rights and Women's Issues, Association of Women Psychiatrists; State Director for New Jersey, American Medical Women's Association

Editorial comment: Views from readers are solicited. The materials have been referred to the appropriate medical society committees.

EDITOR'S DESK



HOME CARE

The American Geriatric Society has estimated that the 25.7 million people aged 65 or older in 1980, expanded to 31.0 million in 1989, and will reach 34.5 million in 2000. Although all those needing home care are not members of this geriatric population, the bulk of them are, and their increasing numbers should be reflected by our increasing concerns about home health care. This month's issue of *NEW JERSEY MEDICINE* hereby is dedicated to home health care.

In testimony given in 1982 about the diagnosis related group system, we noted that patients were being discharged from hospitals earlier than in the past and before they had received the usual measure of care, producing the "quicker and sicker" syndrome. At that time, the home health care agencies had great difficulty in ministering to their charges; the numbers and problems were daunting. Today's system has matured and is able to cope well with most of the medical problems, although the associated difficulties of access, personnel, and reimbursement are more problematic.

The *Newsletter of the American Academy of Home Care Physicians,* pointed out the disgraceful Medicare reimbursement given physicians in one area for home visits: $27.50 per visit compared to $40.65 for home health aides, $67.06 for physical therapists, $68.08 for occupational therapists, $69.33 for skilled nurses, $72.72 for speech pathologists, and $100.24 for social workers (*Federal Register,* March 25, 1991). The inadequacy of payment for physicians is not totally unexpected; the Feds tend to be penny wise and pound foolish. If people cannot receive care by physicians at home, they will wind up in acute care hospitals, at much greater expense. If they are hospitalized for conditions that could have been treated at home, chances also are good that they will deteriorate in this new environment and lose some of their joie de vivre. The activities of daily living tend to be preserved by home health care.

In addition, the "quicker and sicker" syndrome poses a further barrier to the return of good health. Some of you may recall the old narrative that goes, "For want of a nail, the shoe was lost . . .," etc., until finally the kingdom was lost. It is unfortunate that government does not understand the basic principles of economics. But the situation can be helped. The government could allow reasonable reimbursement to the purveyors of care. Better distribution of money could be allocated to home health care, perhaps at the expense of acute hospital care, to allow less out-of-pocket expense for those receiving this most cost-effective activity. The problem will not go away, but will intensify at the same (or higher) rate as the geriatric population increases.

The problems and procedures associated with home care continue to evolve. We are indebted to Doctors Alan Lippman and Michael Rothkopf and to the authors of this special issue. □ Howard D. Slobodien, MD

> *"Old fellows like y'ersilf an' me make a bluff about the advantages iv age . . . . . We have wisdom, but we wud rather have hair. We have expeeryence, but we wud thrade all iv its lessons f'r hope an' teeth."*
>
> Finley Peter Dunne, "Books," *Mr. Dooley Says* (1910)

"An old man loved is winter with flowers."
German proverb

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PRESIDENT 'S PAGE

RBRVS—A PLEA FOR UNITY!

As your president, let me share with you my thoughts about the federal government's new scheme for medicine—resource-based relative value scales (RBRVS).

Beginning January 1, 1992, Medicare reimbursement for physician services is determined through fee schedules set through RBRVS. The ramifications of this overhaul of Medicare Part B are far-reaching and profoundly disturbing.

The profession of medicine does not quarrel with the original concept of RBRVS, which was to create equity between primary care and surgical procedures. But, the profession vehemently protests the government's exploitation of the RBRVS concept as an opportunity to reduce reimbursement overall—despite an earlier agreement, sealed in legislation, to keep reimbursement at current levels.

By now, you should have received a copy of the new applicable fee schedule. Every procedure-oriented specialty is in the minus column. At this writing, the precise impact is unknown, but the losses are substantial for most specialties. For example, ophthalmologists are projected to lose 35 percent of their Medicare revenue; coronary bypass surgeons are projected to lose 31 percent; orthopedic surgeons are projected to lose 19 percent; and general surgeons are projected to lose 15 to 18 percent.

Although the new revisions are unfavorable, the new fee schedules are far worse. Only the strong resistance of organized medicine, which spearheaded a campaign of 100,000 letters to Washington, DC, prevented further reductions of at least 16 percent for all physicians.



Joseph A. Riggs, MD

Furthermore, the decreased fees have the potential to cause much upheaval, as physicians begin to modify their practices to minimize losses. This could possibly lead to a serious access-to-care problem for Medicare patients.

We must continue to resist additional government intrusions into physician-patient relations! No one, except bureaucrats and auditors, perhaps, will benefit from changes that reduce senior citizens to a status close to that of welfare clients.

Along with RBRVS, the federal Health Care Financing Administration (HCFA) had introduced new evaluation and management codes. The new codes are more sensitive to the amount of time that physicians are expected to spend with each patient. HCFA plans to carefully monitor how often a physician records a particular code on a given day. For your own sake, please avoid submitting claims that falsely suggest you routinely work 15-hour days in the office.

It is anticipated that there will be a wide variation in the way physicians respond to RBRVS. Already busy physicians will be able to limit the impact of RBRVS in only two ways: increase productivity or reduce practice overhead expenses.

On an individual level, how can physicians in practice respond to the new system?

1. Physicians, who already tend to work excessive hours, can increase their volume of services, to offset the losses resulting from a lower price per service. This, frankly, is what HCFA has predicted.

2. Physicians, whose overhead expenses have risen rapidly in recent years, can reduce those expenses, again to offset losses from Medicare. Some people predict that many office staffs will be laid off.

3. Physicians and hospitals can adopt practice management techniques to increase productivity and financial results. This combination of options 1 and 2 involves better operating-suite management, more coordinated use of staff during rounds, increasing patient flow, and tighter billing and collection systems.

4. Finally, physicians can alter their patient mix, concentrating on younger, privately insured patients. Doubtless some physicians will decline to accept new Medicare patients. Other physicians may delay appointments and care of seniors. Financial consultants already are advising doctors to seek a younger mix of patients.

It is this fourth option, with the implication that seniors will have less access to care, that should—

but apparently does not—trouble the government. Why does Medicare exist, if not to improve, rather than weaken, seniors' access to care?

Physicians in America are honorable, caring, hardworking, and considerate professionals, and we are the best-trained physicians in the world. We need to continue to marshall our talents, our energy, and our concern to stave off further ill-conceived attacks by government.

Medical societies, including the Medical Society of New Jersey (MSNJ) and the American Medical Association (AMA), have gained new respect among federal and state decision makers because of our strong, well-informed, and positive approach to Medicare issues. But, we need even greater strength if our views are to prevail. No longer should physicians stand aside and alone, watching their profession destroyed by outside forces. More than ever, we must realize how important it is to belong to the *new* MSNJ and the *new* AMA. More than ever, we must stand united in a powerful force.

Let us move forward now, strongly united, in a much more cooperative fashion, to continue the refinement of this complex and historic change in the Medicare program. Let us act to assure that physicians always have a say in how and when they are paid, and that clinical autonomy is retained.

We, in organized medicine, will continue to advance our position aggressively before government and the public. Our goals are to minimize disruptions and degradations in patient care, and to keep medical care in America at its established level of greatness. God bless! ☐ Joseph A. Riggs, MD

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Home Care—New Dimension in Health Care Services

Alan J. Lippman, MD
Guest Editor

Health care services traditionally are provided in a variety of settings, including acute care hospitals, long-term maintenance facilities, private offices, outpatient clinics, and the home. In years past, physicians frequently made house calls for a variety of reasons: lack of private transportation, long travel distances for patients, and, most importantly, administration of treatments that were simple and straightforward. As medical technology became more complex, along with the growth of specialized care, the role of the acute care hospital became paramount and the home became a much less frequent place of health care service.

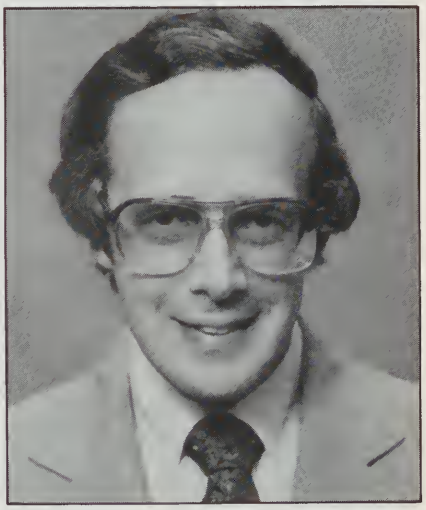
More recently, home health care appears on the ascent, as hospital-based services become increasingly restrictive and limited to acute, intensive specialized care. Growth in this aspect of the medical profession has been rapid; data from the Health Care Financing Administration indicate an average annual growth rate of 20 percent.

There are several reasons for the rise in home care: As the population ages, the elderly and chronically ill require more support and assistance. Advances in medical technology and engineering make it possible to provide sophisticated care in the home. Strict cost controls and prospective payment methods regarding inpatient care force early patient discharge. Patients find that much of the skilled and assistive care they require can be provided in the comfort of their own homes.

Home care best appears to address the needs of certain populations of patients—patients with acquired immunodeficiency syndrome (AIDS), cancer patients requiring hospice support, children who may be ventilator dependent, and patients requiring long-term infusional therapy, including antibiotics, antineoplastics, and parenteral and enteral nutrition. Some newer applications of home care may be superior to comparable hospital services. For example, home study of the sleep apnea syndrome may be more efficient and rewarding when conducted in the comfort of the patient's home rather than in an artificial "laboratory" setting.

Despite the apparent advantages of home care, a number of concerns impede optimum utilization. Physicians, themselves, have been slow to adapt to the movement. Some physicians are discouraged by poor reimbursement, excessive demand of time, liability, and quality of care issues. This lack of physician involvement has prompted the Council on Medical Education of the American Medical Association to recommend that training in the principles and practice of home health care be incorporated into the undergraduate, graduate, and continuing education of physicians.

Further, high-technology home health care has fostered a host of



clinician specialists, including nurses, therapists, social workers, and health aides, supported by a variety of ancillary personnel. Yet, restrictive reimbursement guidelines for federal and commercial insurance plans make it difficult for this industry to compete with salaries and bonuses paid by hospitals.

In such an environment, establishment of quality assurance and maintenance of suitable standards of care become challenging tasks. Regulatory compliance in home health services should be as intensive as in any field of health care. New guidelines have broadened and expanded the responsibilities of Medicare certification surveyors. Documentation of services performed has become more demanding and complex.

In order to enhance their prestige and gain an edge over competing agencies in a rapidly growing field, many home care

organizations have voluntarily sought the accreditation "stamp of approval" from the Home Care Accreditation Program of the Joint Commission on Accreditation of Health Care Organizations (JCAHCO). Such accreditation increases reputability, makes the agencies more attractive when bidding for joint-venture contracts with hospitals, and draws greater recognition from third-party interests. Recently, JCAHCO has appointed a task force to develop criteria for assessing performance in home care infusion therapy. This represents a major new initiative for JCAHCO in the "nontraditional" setting and will further enhance the standards demanded by patients and physicians as they seek to ensure high-quality home infusion therapy.

The New Jersey State Department of Health (NJDOH) licensure of home health agencies includes a vigorous annual survey process. Other accreditation bodies of stature include the National League for Nursing's Community Health Accreditation Program (CHAP), the New Jersey Commission of Accreditation for Home Care, and the National Homecaring Council's Accreditation Program.

The National Association for Home Care (NAHC) is the nation's largest and most broadly based organization representing home care professionals. NAHC provides a variety of services to its membership (now over 5,000), including an annual meeting, numerous educational seminars, regional conferences, and publication of periodicals. The organization also seeks to represent the interests of the industry in governmental affairs.

In New Jersey, home health care activities are overseen by multiple agencies, now united as the Home Care Coalition of New Jersey. This organization consists of the Home Health Agency Assembly (HHAA), the Home Care Council, and the Home Health Services and Staffing Association—all working together to deal with the concerns relevant to providing high-quality home health care to New Jersey citizens.

HHAA currently is developing a code of ethics and membership criteria to identify quality providers. In addition, HHAA plans to assist in the development and support of mandatory licensure for home care in New Jersey. This organization publishes a list of home care providers throughout the state, including Medicare-certified agencies and those providers licensed by NJDOH as well as other certified providers and affiliate members acting as consultants to the industry. HHAA conducts educational seminars and publishes guidelines for provision of safe care in the home.

How can physicians learn to deal with this burgeoning phenomenon in health care and make the most effective use of the myriad of resources?

First, physicians need to become more knowledgeable of ongoing efforts in the home care field. Most physicians are "office centered" and are not accustomed to regarding the home care setting as another extension of the "caring arm" of medical practice.

Physicians should acquire appropriate skills in home health care assessment. They must identify the patients that are suitable candidates for home care technology. Evaluation of the patient's functional and psychosocial status becomes important as well as that of the home environment for safety, functionality, and maintenance. Physicians should be able to evaluate the adequacy of family caregivers, friends, and others who provide personal assistance. What can these individuals realistically contribute and is it adequate for the patient's needs? Knowledge of community resources is imperative. How can these be integrated into the health care plan?

Physicians should be able to evaluate the efficacy of home health care efforts and contribute to improved quality assurance in home health care. Physicians need to be knowledgeable about home health care technology and the applications of special resources in problem-specific situations such as cancer chemotherapy, nutritional support, ventilator dependency, and the particular needs of AIDS patients.

Physicians should be knowledgeable about cost reimbursement policies in home health care. What are the real costs? How are these costs reimbursed by Medicare/Medicaid or private insurance? What is the potential for additional personal costs to the patient and family? Physicians should be familiar with the cost of institutional alternatives to home care and how the cost burden may be advantageous for the latter.

Ultimately, physicians should be able to integrate home, office, and hospital care optimally and to play an active, major role on the home health care team. After all, physicians are responsible for planning and supervising home visits and, whereas most home care will be provided by other professionals, physicians must have experience and rapport with multidisciplinary teams. The traditional "physician dominant" role that exists for the hospital setting is not appropriate in the home care situation. Here, physicians need to acknowledge the skills and abilities of all members of the care team, be available, and be willing to communicate freely with all participants in the process for the fullest benefit of the patient and efficiency of care.

As the practice of medicine prepares for the challenges of the 21st century, home health care will be assuming a more important role. Physicians need to take an active part in shaping policies and directing procedures to ensure that home health care is safe and medically appropriate. ■



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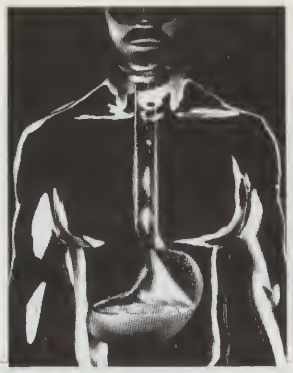
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2. Dosage should be reduced in patients with moderate to severe renal insufficiency.

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Carcinogenesis, Mutagenesis, Impairment of Fertility–A 2-year oral carcinogenicity study in rats with doses as high as 500 mg/kg/day (about 80 times the recommended daily therapeutic dose) showed no evidence of a carcinogenic effect. There was a dose-related increase in the density of enterochromaffin-like (ECL) cells in the gastric oxyntic mucosa. In a 2-year study in mice, there was no evidence of a carcinogenic effect in male mice, although hyperplastic nodules of the liver were increased in the high-dose males as compared with placebo. Female mice given the high dose of Axid (2,000 mg/kg/day, about 330 times the human dose) showed marginally statistically significant increases in hepatic carcinoma and hepatic nodular hyperplasia with no numerical increase seen in any of the other dose groups.The rate of hepatic carcinoma in the high-dose animals was within the historical control limits seen for the strain of mice used. The female mice were given a dose larger than the maximum tolerated dose, as indicated by excessive (30%) weight decrement as compared with concurrent controls and evidence of mild liver injury (transaminase elevations). The occurrence of a marginal finding at high dose only in animals given an excessive and somewhat hepatotoxic dose, with no evidence of a carcinogenic effect in rats, male mice, and female mice (given up to 360 mg/kg/day, about 60 times the human dose), and a negative mutagenicity battery are not considered evidence of a carcinogenic potential for Axid.

Axid was not mutagenic in a battery of tests performed to evaluate its potential genetic toxicity, including bacterial mutation tests, unscheduled DNA synthesis, sister chromatid exchange, mouse lymphoma assay, chromosome aberration tests, and a micronucleus test.

In a 2-generation, perinatal and postnatal fertility study in rats, doses of nizatidine up to 650 mg/kg/day produced no adverse effects on the reproductive performance of parental animals or their progeny.

Pregnancy–Teratogenic Effects–Pregnancy Category C–Oral reproduction studies in rats at doses up to 300 times the human dose and in Dutch Belted rabbits at doses up to 55 times the human dose revealed no evidence of impaired fertility or teratogenic effect; but, at a dose equivalent to 300 times the human dose, treated rabbits had abortions, decreased number of live fetuses, and depressed fetal weights. On intravenous administration to pregnant New Zealand White rabbits, nizatidine at 20 mg/kg produced cardiac enlargement, coarctation of the aortic arch, and cutaneous edema in 1 fetus, and at 50 mg/kg, it produced ventricular anomaly, distended abdomen, spina bifida, hydrocephaly, and enlarged heart in 1 fetus. There are, however, no adequate and well-controlled studies in pregnant women. It is also not known whether nizatidine can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Nizatidine should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers–Studies in lactating women have shown that 0.1% of an oral dose is secreted in human milk in proportion to plasma concentrations. Because of growth depression in pups reared by treated lactating rats, a decision should be made whether to discontinue nursing or the drug, taking into account the importance of the drug to the mother.

Pediatric Use–Safety and effectiveness in children have not been established.

Use in Elderly Patients–Healing rates in elderly patients were similar to those in younger age groups as were the rates of adverse events and laboratory test abnormalities. Age alone may not be an important factor in the disposition of nizatidine. Elderly patients may have reduced renal function.

Adverse Reactions: Worldwide, controlled clinical trials included over 6,000 patients given nizatidine in studies of varying durations. Placebo-controlled trials in the United States and Canada included over 2,600 patients given nizatidine and over 1,700 given placebo. Among the adverse events in these placebo-controlled trials, only anemia (0.2% vs 0%) and urticaria (0.5% vs 0.1%) were significantly more common in the nizatidine group. Of the adverse events that occurred at a frequency of 1% or more, there was no statistically significant difference between Axid and placebo in the incidence of any of these events (see package insert for complete information).

A variety of less common events were also reported; it was not possible to determine whether these were caused by nizatidine.

Hepatic–Hepatocellular injury (elevated liver enzyme tests or alkaline phosphatase) possibly or probably related to nizatidine occurred in some patients. In some cases, there was marked elevation (>500 IU/L) in SGOT or SGPT and, in a single instance, SGPT was >2,000 IU/L. The incidence of elevated liver enzymes overall and elevations of up to 3 times the upper limit of normal, however, did not significantly differ from that in placebo patients. All abnormalities were reversible after discontinuation of Axid. Since market introduction, hepatitis and jaundice have been reported. Rare cases of cholestatic or mixed hepatocellular and cholestatic injury with jaundice have been reported with reversal of the abnormalities after discontinuation of Axid.

Cardiovascular–In clinical pharmacology studies, short episodes of asymptomatic ventricular tachycardia occurred in 2 individuals administered Axid and in 3 untreated subjects.

CNS–Rare cases of reversible mental confusion have been reported.

Endocrine–Clinical pharmacology studies and controlled clinical trials showed no evidence of anti-androgenic activity due to nizatidine. Impotence and decreased libido were reported with similar frequency by patients on nizatidine and those on placebo. Gynecomastia has been reported rarely.

Hematologic–Anemia was reported significantly more frequently in nizatidine than in placebo-treated patients. Fatal thrombocytopenia was reported in a patient treated with nizatidine and another H_2-receptor antagonist. This patient had previously experienced thrombocytopenia while taking other drugs. Rare cases of thrombocytopenic purpura have been reported.

Integumental–Urticaria was reported significantly more frequently in nizatidine- than in placebo-treated patients. Rash and exfoliative dermatitis were also reported.

Hypersensitivity–As with other H_2-receptor antagonists, rare cases of anaphylaxis following nizatidine administration have been reported. Rare episodes of hypersensitivity reactions (eg, bronchospasm, laryngeal edema, rash, and eosinophilia) have been reported.

Other–Hyperuricemia unassociated with gout or nephrolithiasis was reported. Eosinophilia, fever, and nausea related to nizatidine have been reported.

Overdosage: Overdoses of Axid have been reported rarely. If overdosage occurs, activated charcoal, emesis, or lavage should be considered along with clinical monitoring and supportive therapy. The ability of hemodialysis to remove nizatidine from the body has not been conclusively demonstrated; however, due to its large volume of distribution, nizatidine is not expected to be efficiently removed from the body by this method.

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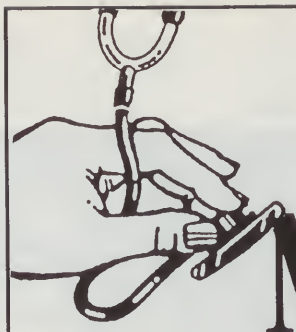
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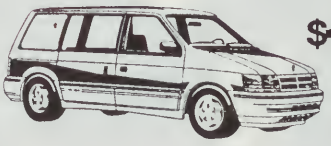
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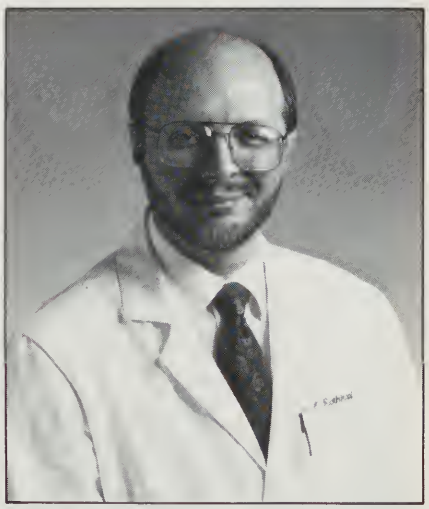
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Intensive Home Care in New Jersey

Michael M. Rothkopf, MD
Guest Editor

Developments in home care will return many aspects of patient care to the home setting. The patient or his family members can be trained to perform many of the activities traditionally done by hospital personnel. Ongoing studies will result in further developments in techniques and equipment.



The February 1991 issue of *NEW JERSEY MEDICINE* celebrated the centennial of St. Elizabeth Hospital. This event will be repeated across the state and throughout the nation as many of America's hospitals turn 100 years old.

As was true throughout the United States, physicians in New Jersey played a vital role in the development of hospitals. The original charters of most New Jersey hospitals list physicians among their members. Some hospitals actually were founded by a single doctor or group of physicians. Other hospitals were the creation of religious or community groups with physicians providing the medical insight into design and development.

Interestingly, the same can be said for the development of home care in New Jersey. Many of the state's home infusion companies are led by members of the medical community. Some have been founded by a single physician or by groups of physicians to care for their own patients.

The "hospital era" of American medicine was advanced by the scientific developments of the late 19th and early 20th centuries. Advances in surgery, anesthesia, and Lister's sterile technique made it necessary to hospitalize more patients to provide the new state-of-the-art therapeutics. The rapid pace of medical science continued as knowledge in chemistry and microbiology created new treatments. In the course of these developments, medicine changed from a simple art practiced in the patient's home to a complex science offering vast new insights for the physician and treatments for the patient. The house call and the concept of care at home were not part of this process.

In contrast, the "home care era" has been stimulated by the need for cost containment and the recognition of psychological and quality of life issues. While hospitals seem driven to more complex technology, the home care movement takes a simpler, more practical approach that often is less costly and more comfortable for the patient. Physicians are beginning to rediscover the value in home visits and treatments.

The new home care is not based on the lone physician bringing his black bag of remedies to the patient's home. Instead, the new home care brings the technology, expertise, and services of the hospital to the patient's home. This process is one with much of the same quality controls as in the hospital environment. However, there are important differences between the two. While hospital care generally places the patient in a position of dependency, home care encourages independence. The elimination of many of the support services necessary for hospitalization (housekeeping, food service, and environmental control) reduces the expense of therapy delivered at home.

Home care organizations provide a wide variety of services, ranging from basic assistance with daily living to artificial ventilation. In order to distinguish between them, home care that replaces hospital services often is referred to as "high tech" or "aggressive" home care. The preferred term is "intensive home care" because it better connotes the degree of medical support provided.

SCOPE OF SERVICES

Intensive home care encompasses home intravenous (IV) infusion, artificial ventilation, dialysis, and pain management. Home infusion therapy currently is the leading use of intensive home care. This includes such treatments as parenteral nutrition, antibiotics, cancer chemotherapy, cardiac medications, and anticoagulation. Recently, New Jersey physicians have begun prescribing infusion of blood products under the auspices of home care.

Home care infusion therapy requires the availability of safe, reliable, long-term vascular access catheters. This development was a major step in the technical ability to provide home infusions. Catheters can remain in place for long periods of time, requiring only basic care.

Devices such as the Hickman® catheter (Davol, Salt Lake City, Utah) exit the skin so that the infusion site can be entered directly. These devices are preferred for the patient requiring daily infusions. Totally implanted devices such as the Port-A-Cath® (Pharmacia, Fairfield, New Jersey) that must be entered through a needle puncture of the skin are used for the patient requiring intermittent infusions, such as chemotherapy.

Catheter lifespan has been increased and infection rates decreased by changes in catheter design and developments in catheter care. Catheters made from such biocompatible material as silastic (silicone/rubber) produce a minimum of inflammation and thrombosis. Therefore, they form less of a nidus for infection. The process of tunnelling the catheter away from the vascular entry protects the catheter site from skin contaminants.

Another important aspect of care for the home infusion catheter involves the use of a sterile occlusive dressing. This system maintains reduced bacterial counts at the catheter site. Such dressings usually are changed two or three times per week. Using these new techniques, catheter sepsis rates among home infusion patients are reported at approximately 1 per 50 catheter-months.

Home infusion solutions are prepared by a home care pharmacy under a laminar flow hood. Most infusion therapies, including parenteral nutrition, are stable for several days after mixing, provided they are kept in refrigerated storage. To assure proper care, home care companies often furnish refrigerators in homes that do not already have sufficient storage space for the materials. In addition, the patient's home should be prepared with the necessary supplies such as IV tubing, infusion pump, dressing kits, heparin flushes, and alcohol swabs.

Home infusion patients must be monitored for adequacy of therapy and complications. Patients should maintain a home care record documenting weight, temperature, and time of infusions. These documents are to be reviewed by the home care nurse for deviation from the care plan. For patients on parental nutrition, regular blood testing for metabolic parameters should be performed. If patients are receiving IV antibiotics, blood levels of the drug often are required as well as renal and hepatic function tests.

Optimal management of a home infusion patient requires active physician involvement. The physician can expect to devote at least one hour per week in reviewing the case, the formulation, the patient's progress on therapy, and the need for adjustments. Additionally, a number of forms and certificates must be completed and signed by the prescribing physician in order to allow for proper billing by the home care company.

ABBREVIATIONS

AWS	AIDS wasting syndrome
CAPD	Continuous ambulatory peritoneal dialysis
CCPD	Continuous cycling peritoneal dialysis
HHD	Home hemodialysis
HPN	Home parenteral nutrition
IPD	Intermittent peritoneal dialysis
IV	Intravenous
NPD	Nocturnal peritoneal dialysis
TPD	Tidal peritoneal dialysis

Home artificial ventilation has been applied for a variety of chronic respiratory patients ranging from those patients completely dependent on mechanical ventilators to patients who only require assistance part of the day. For the former group, the home takes on the appearance of a respiratory care unit. Nurses, respiratory therapists, and family members all participate in patient care. While chest physiotherapy, tracheal suctioning, and administration of nebulized medications traditionally require assistance, highly motivated patients may perform some of these activities themselves.

In cases where the patients receive intermittent ventilatory support at home, such as night-time rest with assisted ventilation, less staff and equipment are required. These patients often depend only on spouses or other family members to help them perform the therapy.

Because of the technical requirements of the machinery used for home artificial ventilation, a review for adequate environmental conditions is necessary. Some ventilators require special electrical current and backup power. Facilities must be in place to provide for continued therapy in the event of a power failure. When high concentration oxygen is used at home, proper storage facilities are required as well as fire safety precautions.

Home dialysis is utilized by 20,000 patients. The majority of these patients receive continuous ambulatory peritoneal dialysis (CAPD). CAPD is a simple procedure requiring limited technical skill. The entire procedure is performed using gravity drips. Generally, the solutions for



CAPD are changed only four times per day, allowing for continuous, gradual dialysis without significant interruption of a patient's lifestyle.

A growing percentage of patients now are opting for machine-delivered home dialysis. Such methods as intermittent peritoneal dialysis (IPD), continuous cycling peritoneal dialysis (CCPD), nocturnal peritoneal dialysis (NPD), and tidal peritoneal dialysis (TPD) have been used with selected patients.

Hemodialysis also has been performed at home. Home hemodialysis (HHD) predates many other methods of home dialysis. Although its use has declined recently because of financial constraints, HHD is a safe alternative to in-center hemodialysis for motivated patients.

Morphine and its semisynthetic derivatives have been safely administered by continuous drip at home. Narcotics also can be administered at home via the subcutaneous or epidural routes. The dosage may be adjusted to control pain without clouding the mental status.

These systems generally employ small, computerized infusion pumps programmed to continuously deliver the correct dosage. Additional bolus doses also can be programmed into the units with predefined restrictions as per the physician's order.

PATIENT POPULATION

Intensive home care has been used effectively in the treatment of numerous diseases. These diseases can be categorized in broad terms based on the type of therapy. Home parenteral nutrition (HPN) is best used as an "artificial gut" for patients with primary bowel dysfunction. In its early use, HPN was limited to those with congenital bowel disease but soon was extended to adults with such disorders as short bowel syndrome, ischemic bowel syndrome, and severe inflammatory bowel syndrome.

Patients with bowel obstruction secondary to cancer or bowel dysfunction due to radiation or chemotherapy also have benefitted from HPN. However, the extended use of HPN in cancer patients remains an area of some controversy.

Recently, I have studied the use of HPN for the management of AIDS wasting syndrome (AWS). We have demonstrated that, contrary to popular belief, many patients with AWS can be safely treated with HPN. In our experience, 30 percent of AWS patients can be effectively managed by HPN, resulting in weight gain and nutritional recovery.

IV antibiotics have been used with good results in various patients requiring long-term therapy, such as patients with fungal illnesses that may require months of antifungal treatment. Other common diagnoses treated with home IV antibiotics include: osteomyelitis, endocarditis, Lyme disease, and the fetid foot syndrome. Once again, AIDS is becoming a major indication for the use of home IV antibiotics, either for treatment or prophylaxis.

It is important to recognize that while many patients have illnesses that can be appropriately treated with intensive home care, not all such patients are proper home care candidates. Since the system relies on a patient and family member to assist in the therapy, they must be motivated to perform the necessary activity. A certain amount of dexterity and visual acuity also is required. Additionally, social factors, such as the adequacy of the home environment and the availability of family members to provide emotional support, play an important role in the success of home intensive therapy. Therefore, careful screening for patient selection always should be part of the initial home care process.

ECONOMIC ADVANTAGES

The major motivation for the use of intensive home care is the economic advantage to the health care system. For example, estimates of hospital costs following uncomplicated surgery may range from $300 to $500 per day compared to $25 to $75 per day for the same care at home. A study by the Veterans Administration reported that treating

2,000 patients with home care for an average of 19 days saved the system $15.9 million. In a study of intensive care costs, hospital costs for an infant requiring ventilatory and nutritional support were $60,900 per month compared to equivalent care at home for $20,200 per month.

A recent study on the cost of treating AIDS patients showed that the average hospital cost was $750 per day compared to $200 per day for comparable care at home. Furthermore, based on existing reimbursement standards, the average hospital lost money treating AIDS patients whereas the home care company profited.

A recent study reported that diagnosis related groups and other cost-containing measures reached their maximum effectiveness during the 1980s and cannot be expected to contribute to further cost reductions. Further savings in the health care system will require alternatives to hospitalization. Intensive home care offers the ability to reduce costs while maintaining an appropriate level of care.

SUMMARY

The concept of intensive home care will return many aspects of patient care to the home setting. The patient or his family can be trained to safely perform the activities traditionally done by hospital personnel. This will result in an improved quality of life for many chronically ill patients and significant cost savings to our health care system. ■

Dr. Rothkopf is director of nutritional support, Saint Barnabas Medical Center, Livingston; and a consultant in nutrition and metabolism at The Hospital Center at Orange, Overlook Hospital, and Newark Beth Israel Medical Center. Requests for reprints may be addressed to Dr. Rothkopf, 124 East Mount Pleasant Avenue, Livingston, NJ 07039.

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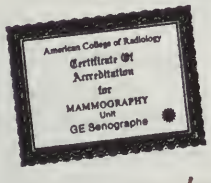
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Home Parenteral Nutrition

Kenneth J. Storch, MD, PhD

Patients who are unable to sustain their nutritional integrity with foods or intestinal feedings still may be able to thrive in the home setting. A concerted health care team approach, which includes the patient and family, is required to safely carry out long-term home parenteral nutrition.



The advent of parenteral nutrition (PN) in the 1960s gave physicians the capability to support intestinally handicapped patients for indefinite periods of time. This set of new and complex technologies was hospital-bound at its inception. The high rate of infections and metabolic complications warranted strict monitoring and nursing care. Catheters had not yet been developed for long-term, out-of-hospital use. Patients who had absolute requirements for PN were stranded within the hospital or forced to undergo frequent hospital readmission for intermittent treatments.

The technical barriers have diminished over time. Catheters designed for long-term use have decreased the incidence of infection associated with PN. Home care systems are functioning in most locations. Parallel advances in self-monitoring techniques, e.g. home blood glucose monitoring, have improved the level of care available to PN patients at home. In 1986, it was estimated that 2,000 to 5,000 patients were receiving home parenteral nutrition (HPN) in the United States. HPN is practical and, when skillfully provided, highly cost effective.

LONG-TERM VENOUS ACCESS

Catheter designs are continually being changed and improved. Prevention of venous thrombosis and catheter infections are among the most critical issues. The most commonly used catheters, such as the Hickman® Catheter (Davol, Salt Lake City, Utah), are made of silastic, a durable substance with relatively low thrombogenicity. The catheter is tunneled through a subcutaneous tract to provide additional protection of the venous entry site. The subcutaneous tunnel is protected further by a Dacron® cuff, a small Dacron® ring around the catheter designed to promote a fibroblast response. This results in a collagenous barrier within the subcutaneous tunnel that impedes the migration of bacteria from the skin to the inner part of the tunnel.

A significant advance has been the development of subcutaneous reservoir ports, accessed intermittenly with specially designed (Huber) needles. This allows the patient to shower, bathe, and swim without concern of catheter tract infection. The use of a port is most practical if intravenous (IV) access is not required on a daily basis, so that the needle can be removed for long periods of time. Obviously, there is a cosmetic advantage for the patient since no catheter protrudes from the skin. Infection rates are reported to be lower with ports than with older types of catheters. However, this may not be true if the Huber needle is allowed to remain in situ continuously for prolonged periods.

Decreased infection rates have been reported with catheters that contain antibiotic molecules bonded onto the surfaces. Silver-impregnated catheter cores also have been shown to reduce infection rates.

INDICATIONS

The patient population receiving HPN has been growing steadily since the technique was first applied in the mid-1970s.

HPN is appropriate for patients who are unable to meet their nutritional requirements by the

oral or enteral routes for a prolonged period of time. Generally, there is a serious disturbance of gastrointestinal (GI) function. Some patients, however, are able to continue limited oral or enteral tube nutrition. Whenever possible, the intestinal route should be utilized, e.g. feeding jejunostomy infusions.

The function of the GI tract may be disturbed by one or more mechanisms. Obstruction, perforation, bleeding, malabsorption, and fistulization have the potential to disrupt GI nutrition and make PN essential. When metabolic demands are increased due to a chronic condition, milder impairments in GI function may result in inanition, requiring parenteral support.

Fistulae, whether enterocutaneous or internal, often are an indication for long-term PN. Malnutrition may occur due to inadequate intake, increased GI losses, or increased requirements associated with a septic focus. Fluid and electrolyte imbalances are readily managed by adjusting the electrolyte content of the parenteral fluid. Healing of certain fistulae may be hastened by bowel rest. Elemental or low residue diets may suffice in lower intestinal fistulae. With upper intestinal fistulae, it is preferable to totally discontinue enteral feeding, necessitating parenteral support for healing and for homeostasis.

Short bowel syndrome is seen in patients with extensive small bowel resections (greater than 70 percent). These patients frequently are unable to absorb enough nutrients to meet their requirements. To avoid malnutrition, severe diarrhea, electrolyte and acid-base imbalances, and eventual death, such patients often require long-term PN. Bowel adaptation may occur within a period of six months to three years at which time HPN may be weaned.

With patients enduring chronic or repeated episodes of partial obstruction, e.g. abdominal or pelvic neoplasms, HPN may be required to avoid inanition, vomiting, or third spacing with resultant fluid-electrolyte disturbances or acid-base imbalances. The same is true for patients with disorders of GI motility resulting in a pseudo-obstructive clinical pattern. Advanced cases of scleroderma may progress to this point. Patients with myopathic or neuropathic conditions involving the bowel and patients with diabetic gastroenteropathy are also in this situation.

Severe Crohn's disease is a frequent indication for HPN. Some patients may have undergone bowel resections, leading to short bowel syndrome. Fistulization is a relatively common complication. Growth failure of children with Crohn's disease has been reversed with long-term home nutritional support.

Radiation enteritis may cause several of the functional disturbances described, requiring parenteral support.

HPN is indicated in carefully selected patients with disseminated neoplasms. A controversy exists as to whether or not parenteral nutrition feeds the tumor as well as the patient. However, the patient with wasting secondary to intestinal obstruction and/or tumor-related catabolism may deteriorate rapidly. If oral and enteral approaches fail, such a patient may be denied specific treatment of the tumor. Such adverse consequences of malnutrition often are preventable and may be reversible with parenteral nutrition.

Patients with extensive postoperative adhesions involving the abdomen or pelvis often become severely malnourished before surgery. A course of HPN may be required to prepare for an elective procedure. When the inflammatory process has waned and the patient is repleted, there is a decreased likelihood of new complications.

Occasionally, patients with prolonged, severe hyperemesis gravidarum may require parenteral nutrition for weeks or months.

A wide variety of acquired and congenital disorders may require long-term parenteral support when malabsorption and wasting become life-threatening. Among these disorders are cystic fibrosis, chronic pancreatitis, AIDS enteropathy, intractable sprue syndromes, congenital malformations of the intestines, graft versus host disease, intestinal lymphangiectasia, hereditary hemorrhagic telangiectasia, and paraneoplastic syndromes.

ADMINISTRATION

PN usually is administered continuously in hospitalized patients. In the home environment, the solution is typically infused overnight ("cyclic" PN). The overnight cycle allows for more normal daytime activities. In addition, the daily cycle of fasting alternating with alimenting appears to be more compatible with physiologic processes and may prevent certain complications, such as hepatobiliary dysfunction. The full day's requirement of fluid, glucose, lipid, and other nutrients is given over a shorter interval (typically 9 to 12 hours). Therefore, it is important to monitor the patient's tolerance of the rapid infusion and ability to clear the nutrient load. In particular, such complications as congestive heart failure, hyperglycemia, electrolyte imbalance, and hypertriglyceridemia must be considered. This often is done before discharging the patient from the hospital by advancing the infusion rate and shortening the infusion duration progressively over two or more days.

For patients with glucose intolerance, it often is necessary to add insulin to the PN solution to avoid signifcant hyperglycemia. In addition, it may be helpful to reduce the quantity of dextrose and use lipid emulsion to provide the balance of calories. This must be done carefully to optimally balance the ratio of glucose and insulin. It may be necessary to run hyperalimentation continuously (rather than an overnight cycle) in

a brittle diabetic. An understanding of insulin kinetics, glucose clearance, and lipid clearance is fundamental to the safe administration of PN to the diabetic patient.

FORMULATIONS

Since the early 1980s, PN admixtures containing lipid emulsion mixed with amino acids, dextrose, and the other routine additives (electrolytes, minerals, trace elements, and vitamins) have been available in the United States. The European experience dates back to the mid-1970s. These solutions usually are administered in plastic "bags" with a capacity of two to four liters. Thus, an entire supply of fluid and nutrients can be prepared and delivered in one bag. This simplifies the process of ordering, compounding, storing, and administering the HPN solution. This type of PN is referred to as a "three-in-one," a "triple-mix," or a "total nutrient admixture" (TNA).

There are some drawbacks to TNAs. Firstly, the lipid emulsion has the potential to separate from the aqueous components. If the tiny lipid particles coalesce into larger particles ("creaming out"), a fat embolism can occur. Fortunately, this complication has not been reported to any significant degree. Secondly, the lipid particles cannot pass through small (0.22 micron pore size) in-line filters. These often are used to remove bacteria from dual-component PN solutions. As an alternative, some centers have employed a larger (1.2 micron) in-line filter. This removes fungi, particulate matter, and a high percentage of bacteria. Use of TNA has not been found to result in significantly higher sepsis rates.

Thirdly, TNA solutions often are less compatible with intravenous pharmaceuticals and other additives that occasionally are added within PN solutions. It may be necessary to administer IV pharmaceuticals through a separate line or lumen of a multilumen catheter or a double subcutaneous port.

Metabolic acid-base disturbances often are corrected with the PN solution. In metabolic acidosis, sodium and/or potassium can be delivered as their acetate salts. Acetate is converted to bicarbonate by aerobic tissues. Bicarbonate usually is not added directly to PN solutions due to the insolubility of calcium. However, an abnormal anion-gap may indicate that the acetate is not being metabolized to bicarbonate and is accumulating in the blood. The management of hypochloremic alkalosis may include increased levels of chloride salts, e.g. NaCl, and, rarely, added hydrochloric acid (the latter is not compatible with TNAs).

HPN COMPLICATIONS

Early problems of PN include: mechanical complications of central venous catheterization, e.g. pneumothorax, acute or metabolic complications, e.g. hyperglycemia and hypophosphatemia, and subacute metabolic complications, e.g. the exacerbation of CO_2 retention in a patient with chronic obstructive pulmonary disease (COPD).

The spectrum of PN-related complications changes with the duration of PN. Catheter sepsis and chronic metabolic complications are more likely to arise in the setting of long-term PN.

Metabolic complications usually are manageable by modifying the HPN formulation, without hospitalization. The majority of HPN-related readmissions to the hospital are due to catheter sepsis. Other catheter complications such as catheter perforation or occlusion often are managed by corrective procedures at home.

CATHETER INFECTIONS

Despite advances, catheter infections continue to be a significant complication of HPN. Any part of the catheter may become a site of infection. Management of an infection may differ, depending on which part of the catheter is involved.

Most catheter infections are caused by normal skin organisms, including *Staphylococcus* and *Candida* species. Fungal infections usually are managed with catheter removal. However, bacterial infections have been treated successfully with intravenous antibiotics. This frequently has obviated the need for catheter removal.

The intra-lumenal portion of the catheter becomes lined with a sheath of fibrin and other plasma proteins. An infected catheter may contain microorganisms within this fibrin sheath. Therefore, even if systemic signs of infection, e.g. fever, have been eliminated with antibiotic therapy, prolonged therapy may be necessary. Catheter removal is and probably always will be the "gold standard" procedure for treating infected catheters.

The "antibiotic lock" technique utilizes a small amount of concentrated antibiotic (or antifungal) instilled within the catheter and capped so as to remain within the catheter at levels that far exceed those generally required for efficacity. This has been used with encouraging results in catheter salvage studies.

Empirical therapy often is initiated before deciding whether or not to remove the catheter in the febrile, but nontoxic, patient. Vancomycin commonly is used in this application due to its high level of success against staphylococcal infections. Amphotericin is the hallmark of treatment of *Candida* sepsis. A role for fluconazole may be emerging, especially in empirical treatment of catheter-related infections while awaiting blood culture results.

METABOLIC COMPLICATIONS

Hepatic dysfunction may be seen in patients on long-term PN. This often is due to the primary diseases for which the patient is



under treatment. However, the incidence of cholelithiasis is increased in HPN patients and also in its most classic indication—patients with short bowel syndrome.

The nature of hepatic dysfunction caused specifically by PN is poorly understood. Available evidence suggests that it is multifactorial and heterogeneous in etiology. The findings may include abnormalities in various indices of hepatic function, including bilirubin, alkaline phosphatase, and transaminase levels. The patient may progress to frank jaundice. Fatty liver and cholestasis may be seen.

Excessive glucose administration seems to be a contributing factor to the syndrome. The consequence of this is increased lipogenesis (oxidation of glucose with hepatic production of triglycerides) beyond the rate at which very low density lipoprotein (VLDL) particles can be exported from the liver. Another possible cause of TPN-related hepatic dysfunction could be an idiosyncratic reaction to the intravenous lipid emulsion. Bowel pathology resulting in increased portal venous absorption of bacterial endotoxin also may be a factor.

The optimal formula to prevent hepatic dysfunction contains adequate levels of nitrogen (amino acids) and a nonexcessive level of calories balanced between dextrose and lipid. Nutritional measures to maintain integrity of bowel structure and absorptive function offer potential future avenues for prevention of TPN-related hepatic dysfunction. The use of glutamine and sources of short-chained fatty acids, such as certain types of dietary fiber, have been proposed in this regard.

A peculiar metabolic bone disease has occurred in some HPN patients. Characterized by abnormalities in calcium and phosphorus homeostasis, it often results in osteomalacia, bone pain, and fractures. By 1987, over 50 cases had been reported in North America. Various etiologic factors have been suggested including infusion of excess vitamin D, aluminum, calcium, protein, or glucose; continuous cyclic versus PN administration; previous nutritional status; and lack of mobility. The management of metabolic bone disease seen in the HPN setting is complex and controversial.

Other long-term metabolic complications include deficiencies of nutrients, including essential fatty acids, magnesium, iron, vitamins, and trace minerals (Zn, Cu, Se, Cr, Mn, and Mb).

MANAGEMENT ISSUES

Evaluation of patients for HPN should be made carefully by a multidisciplinary nutrition support team to determine that such an endeavor is safe and practical. Simpler alternatives, such as home enteral feedings, are preferred.

A hospitalized patient requiring long-term PN may be discharged and maintained on HPN if an acceptable level of care can be generated at home. Therefore, the mental and emotional status of the patient must be considered. A patient who is disabled by a neurologic process or who is emotionally unstable cannot be relied upon to participate appropriately. The management of the central venous access and the safe administration of the concentrated, sterile solutions require total compliance. The patient or a member of the patient's support system usually are needed to participate in the monitoring and care of the HPN patient. This usually is a family member living with the patient. The techniques of routine care of the IV access catheter (or port) must be mastered. Training is accomplished by physicians and nutrition support specialists familiar with the procedures and complications of HPN. If the home environment is found to be unsuitable, HPN should not be attempted.

If the medical condition of a hospitalized patient is unstable or requires frequent monitoring by a skilled health professional, it is unlikely that discharge to the home will last long. It may be more appropriate to continue the hospitalization until the likelihood of a successful long-term course of home care is strengthened.

Long-term PN patients without adequate home resources could potentially be placed within extended care facilities. As yet, this has not been practical due to the lack of third-party reimbursement for the high level of care required. Without close supervision, septic and metabolic complications are more likely to develop.

The patient is normally examined a week after discharge and on a regular basis thereafter. The frequency of visits, of course, is determined by the complexity

and rate of change in the patient's condition. Blood and urine specimens are collected at home by home care nurses as needed. HPN patients should be reassessed periodically regarding the need for, and benefit of, continuing home care.

HPN requires the ability to perform a complex medical technology at home, on an ongoing basis. Often, the patient is excluded from the social function of eating. These psychologic stresses challenge the mental well-being of the patient. Psychiatric care and emotional support groups should be available. Most patients adjust well, but depression, organic mental syndromes, and delusions may occur and should be managed appropriately.

DURATION OF HPN

Depending on the reasons for which HPN was required, a patient may be on HPN for weeks, months, or years. Patients with short bowel syndrome usually reach maximum absorptive function within 6 to 12 months. Therefore, patients who have been on HPN for a year usually will require it indefinitely. In the future, HPN may become a means of support for such patients awaiting a bowel transplant.

SUMMARY

HPN is an effective means to maintain the nutritional well-being of patients whose medical conditions prevent adequate oral or enteral nutrition on a long-term basis. It has been found to be safe when experienced health professionals, the patient, and the family work together in a team approach. ■

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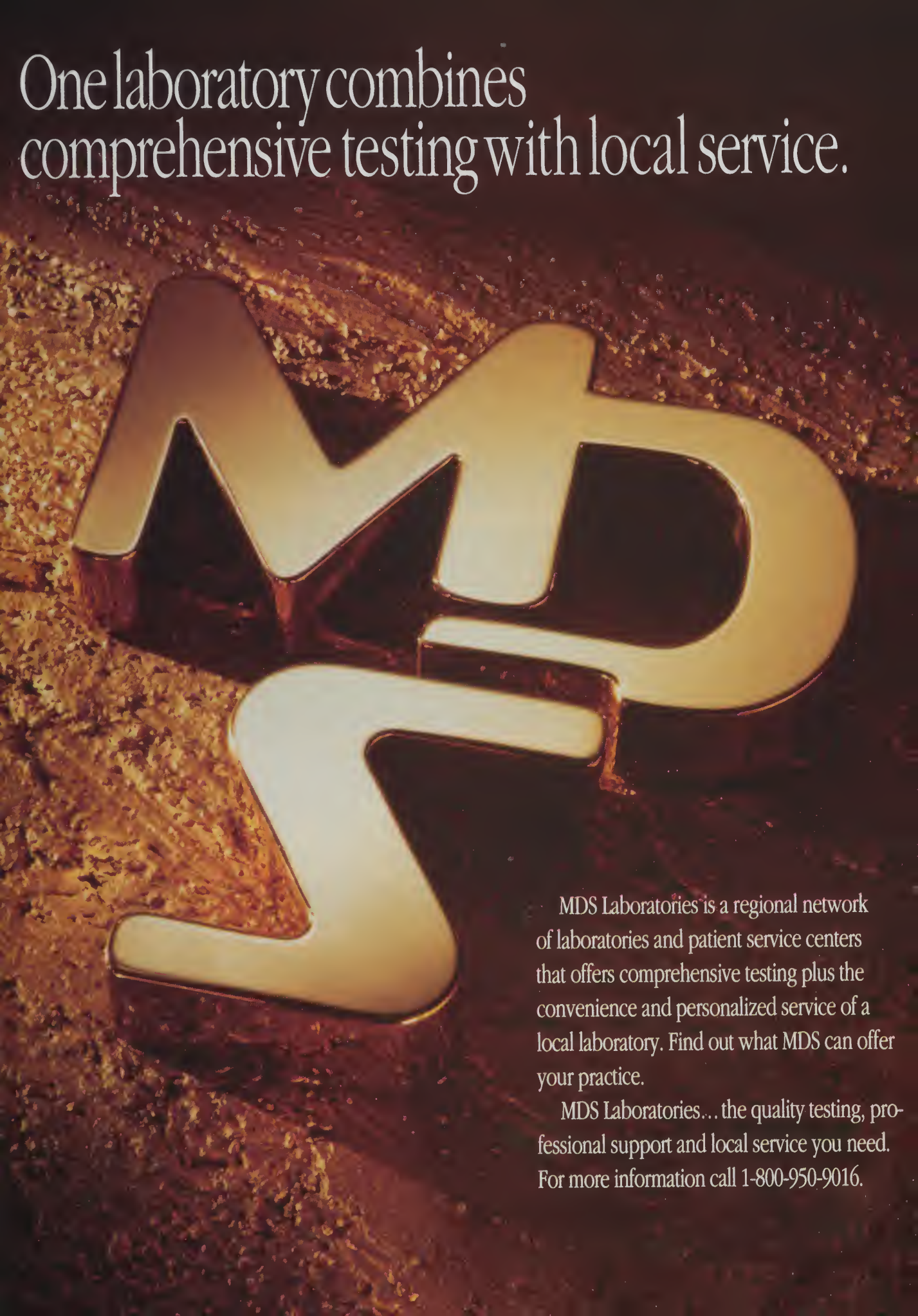
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Dr. Storch is Chairman, Nutrition Committee, Overlook Hospital, Summit; and is president-elect of ASPEN, the New Jersey Chapter of the American Society for Parenteral and Enteral Nutrition. Requests for reprints may be addressed to Dr. Storch, 2333 Morris Avenue, Suite B-13, Union, NJ 07083.

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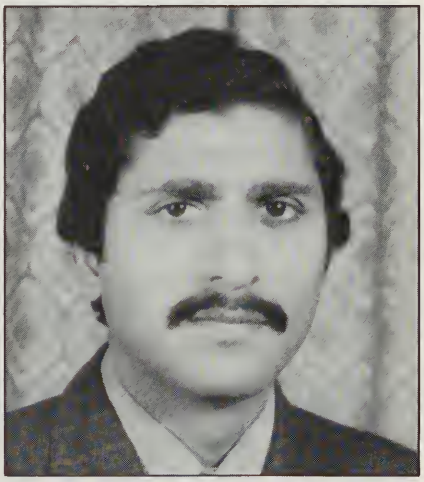
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Home-Based Intravenous Therapy for Oncology Patients

Tariq Mahmood, MD
Arnold D. Rubin, MD

It is desirable to keep cancer patients at home whenever possible to maximize their physical comfort and mental well-being. However, physicians should be aware of all the serious limitations in terms of patient selection and avoidance of the abuses of overutilization of the system.





There has been a growing interest in providing cancer patients with intravenous therapy in the home. This development has grown out of a desire of many patients to stay out of the hospital, particularly since cancer patients spend so much time as inpatients during their illnesses.

There has been much support for intravenous home therapy. Government and insurance agencies want to avoid the great expense of hospitalization. Patient advocate organizations feel patients do better in home environments. The recent abundance of trained personnel provided by hospitals and the availability of expertise in ex-urban communities have added greatly to the impetus for decentralization of cancer care. Well-developed hospice programs already have shown great success in bringing home-based care to the advanced and terminal cancer patient. Much can be learned from this modality in terms of patient comfort and convenience. Finally, the obvious profit incentive has whetted the appetites of venture capital and other businessmen capable of organizing companies to deliver home care.

Many patients with cancer can be cared for in the home without recourse to intravenous therapy. These patients may receive no active therapy, may be receiving oral drugs, or may be receiving intermittent chemotherapy in doctors' offices. Such patients are not part of the present discussion since they already enjoy freedom from the organized structure of health care delivery. This discussion will deal with those patients who require regular or sustained intravenous management.

The major advantages of delivering intravenous care at home are the convenience and comfort of the home environment. Transportation also is an advantage for those patients who do not travel easily. Older people particularly enjoy the familiar home environment and usually are stressed by hospital surroundings. This psychological advantage is a major factor in the management of many cancer patients. Furthermore, hospital schedules often are geared toward a different type of patient who will remain in the hospital for several days. The scheduled short-term intravenous therapy patient may be lost in the bustle of emergencies and urgencies common to all hospitals. Still, many hospitals maintain organized "same-day units" that are designed to be more like home environments and are not distracted by unanticipated demands of the acute care units.

It is assumed that home care is more cost effective because patients pay only for the care they receive. The cost of therapy for a day in the hospital is based on a complicated procedure that takes into account many other factors

that do not play a role in the care of short-term therapy patients. Health maintenance organizations potentially can avoid the high per diem rate charged by hospitals when they negotiate with a private company specializing in home care delivery.

Thus, from the point of convenience, comfort, and low cost, home intravenous therapy seems to offer major advantages. For this reason, there has been tremendous growth in the number of home care companies.

One must consider other factors that may temper some of the enthusiasm. The number of patients who might be considered appropriate for home intravenous therapy is quite limited. Their medical conditions must be stable. Home therapy is appropriate only if patients need minimal close observation. An intravenous catheter route is extremely important. Most of the chemicals infused through this intravenous route are potentially damaging and locally corrosive if there is leakage outside of the vein. Therefore, the venous access must be absolutely secure. This is only insured by the Hickman® catheter or the indwelling Port-A-Cath® reservoir. These devices require care and may become fouled, infected, or clogged. Septicemia from infected catheters or indwelling reservoirs is not uncommon. Some of the requirements for home intravenous therapy are outlined in the Table. There is a rather extensive responsibility undertaken by the home intravenous therapy company. There must be qualified personnel as well as equipment and expertise. The potential for untoward events is great.

With home intravenous therapy, there is a loosening of the bonds between patients, physicians, and hospitals. This results in some loss of continuity with staff familiar with overall care, and is not a very desirable development. The home intravenous therapy company should try to maintain strict continuity.

The patient may have to visit the physician more often for evaluation and rethinking of the therapeutic management. Unfortunately, some intravenous therapy companies simply rely on telephone conversations with the physician who may be contacted at times when he does not have access to the chart or may be distracted by his regular duties so that full concentration cannot be directed toward the problem.

By its very nature, the home intravenous therapy company has a rather limited response to emergency developments such as allergies or abrupt changes in a patient's condition. As these developments may grow out of the intravenous therapy, there may be an inordinate delay before the patient comes under definitive care. Clearly, this would not be the case were the patient to be treated in a hospital environment.

There also are economic concerns pertinent to society. Same-day units in hospitals are the usual areas in which intravenous therapy now is conducted. These units represent a low-cost source of income. This loss of income would result in a further rise in the cost of hospital maintenance. And this rise eventually would be the concern of government and insurance agencies; only the home intravenous therapy company would enjoy a financial gain.

Finally, the home intravenous therapy company may duplicate what already is available to some extent in the doctor's office. There are situations where intravenous therapy is relatively simple and can be performed just as well in the doctor's office. This would place the physician in a difficult and competitive situation with a home intravenous therapy company. In many of these situations, the patient has to come to the doctor's office for evaluation. It would make little sense to send a patient home for a short intravenous infusion that could be performed during an office visit.

Thus, there is a clear advantage of home intravenous therapy for a limited number of patients under specific circumstances. Potential problems of home intravenous therapy over a long period of time must be considered.

Home-based care can be divided into four main categories.

Home-based Chemotherapy. Many types of intravenous chemotherapy can be given at home. There seems little justification for administering intravenous push medication at home when it can be adequately administered for less money in the physician's office. Thus, methotrexate, 5 fluorouracil, and cytoxan regimen for adjuvant chemotherapy of breast cancer requires re-evaluation of the patient prior to each course. The push medication can be given following the evaluation in the physician's office. The doses of these chemotherapeutic agents and combinations are designed by the oncologist at the time of the visit.

Prolonged infusion may be defined as intravenous treatment requiring more than one hour to administer. These regimens would be most suited to home-based chemotherapy. Examples include a combination of vincristine, adriamycin, and dexamethasone over a five-day interval. The regimen requires very little monitoring and home-based blood counts can be arranged for optimum safety. Other examples include a five-day infusion of fluorouracil with an overnight infusion with cisplatin commonly used in the treatment of lung cancers and head and neck tumors. This also requires relatively little monitoring while the patient is receiving the medication. For a bowel cancer patient, a six-week regimen can be designed in advance: each week the patient receives a two-hour infusion of leucovorin interspersed with an intravenous push of 5 fluorouracil. Toxicity is significant but monitored best by symptomatology. The patient can be managed in the home environment with careful nursing observation.

Even overnight infusions of cisplatin with short infusions of VP-16 can be designed by the physician to be administered at home with little monitoring. However, the patient still would require office visits for evaluation at least once a month. All of these regimens require frequent laboratory monitoring to ensure that blood counts, electrolytes, and chemistries are under good control, since toxicity to the bone marrow is significant and also many of the agents will induce abnormalities of fluid and electrolyte balance.

Most importantly, these regimens can be administered at home only if the patient is medically stable and not suffering from significant toxicity. Because of the brittle nature of many cancer patients, it is absolutely critical that the decision as to the appropriateness of home therapy be entirely decided by the managing oncologist. This decision cannot be based on economic considerations. Furthermore, it would be difficult to prepare the criteria that one could use to judge the appropriateness of home chemotherapy. Only the oncologist, with insight into the disease and the patient's general condition, can make such a subjective judgment.

Home-Based Antibiotic Administration. Cancer patients frequently develop fungal, viral, or bacterial infections, especially during chemotherapy courses. These often are associated with leukopenic episodes and are based on an immunocompromised state. Not uncommonly, the catheter itself is the nidus of an infection resulting in septicemia. These patients require prolonged courses of antimicrobial treatment. After several days of antibiotic treatment, some patients may be quite stable and appropriate for discharge, and could continue with home intravenous therapy. Fungal infections are particularly good examples of this situation.

Once a patient develops a fungal infection, there is a required optimal cumulative dose of amphotericin B. This could be given as an every other day administration and in a stable dose. It certainly is reasonable to administer this sort of medication at home with appropriate monitoring.

Other situations where septicemias or bacterial infections are treated with long-term antibiotics such as vancomycin, completion of treatment in the home is perfectly appropriate. The same would be considered true of certain infections such as herpes zoster where the patient is comfortable and stable but requires a ten-day course of intravenous acyclovir.

Home-Based Hyperalimentation. Many cancer patients become malnourished due to their underlying malignancy. Patients become aggravated by the side effects of chemotherapy or the inability to eat because of mechanical complications in the upper alimentary tract. Where there is significant dysphagia associated with esophagitis or obstruction of the upper alimentary tract due to tumors, intravenous nutrition may be lifesaving. Some patients have resistant nausea and vomiting precluding their ability to take in significant nutrition. Most of the situations where there are mechanical or other problems precluding the ability to swallow and keep food down are amenable to improvement by total parenteral nutrition (TPN).

A patient who simply is wasted by the ravages of the disease most likely would not benefit by this artificial means of nutrition. In any event, TPN can be administered at home assuming there is no other reason to keep the patient in the hospital. With those situations where the patient is physically and metabolically

Table. *Physician and patient considerations of home health care.*

Patient Selection		
	Physical	Diagnosis, performance status, venous accessibility, drug characteristic, and required laboratory work.
	Psychological	Desire to participate in care; adequate support care.
	Environmental	Cleanliness, telephone access, storage space, and availability of emergency care.
Informed Consent		Patient and family must understand underlying risks.
Insurance Reimbursement		Explored in advance of any decision.
Support Services		
	Certified Home Health Agency	Establishment of policies and procedures. Twenty-four hour telephone service. Quality assurance program.
	Laboratory	Independent, local hospital, and physician office.
	Pharmacy	Consultation, preparation, and delivery of drugs.
Nursing Qualification		Administration of chemotherapy; related toxicity and related interventions; implementation of psychological support; chemotherapy infusion device (internal/external); pumps and venous access devices; management of extravasation—anaphylaxis; hazardous waste handling; and comprehensive documentation to meet regulatory reimbursement guidelines.
Patient/Family Education		Medical regimen; ambulatory infusion pumps; venous access devices; and disposal of hazardous wastes.

stable, a regular recipe can be designed for home TPN. Again, the choice of appropriateness must be up to the physician. If the patient is metabolically brittle and requires frequent adjustments of electrolytes and carbohydrate metabolism, the physician could make these adjustments over the telephone.

Pain Management. When active therapy fails, pain control becomes a major problem in oncology. The first approach is to administer long- and short-acting oral narcotics in optimal combinations. However, there frequently are situations, such as multiple myeloma or breast cancer metastatic to the bone, where intractable pain becomes the overriding problem. These patients can be controlled with intravenous treatments. State-of-the-art procedures now call for patient-controlled parenteral therapy. There are systems set up for reservoir narcotics to be administered by patients on demand. Anesthesiologists or pain clinics can provide coverage with hospices or visiting nurses with no need of additional assistance. There are situations where patients are not in a condition to control pain and morphine drips are the last resort. This can be administered at home with an intravenous catheter and a solution of the appropriate concentration. The patient's family can titer the pain relief according to the degree of consciousness and level of pain. Close nurse monitoring is required for optimal results.

CONCLUSION

Patients and their families have to be educated about the goals and objectives of the home intravenous therapy regimen. The Table outlines a series of considerations the physician must discuss with the patient and his family. It is clear that the goals of treatment and the regimen involved must be understood. The technical problems involved in pump management and care of the port site are of equal importance as problems in these areas can result in serious complications.

Home-based intravenous therapy is an attractive alternative for managing the cancer patient outside the hospital environment. The important caveat in this consideration is that the physician must pay close attention to whether a patient meets all of the essential requirements necessary for success. Whether this type of management can reduce costs, if employed appropriately, remains to be proved. ■

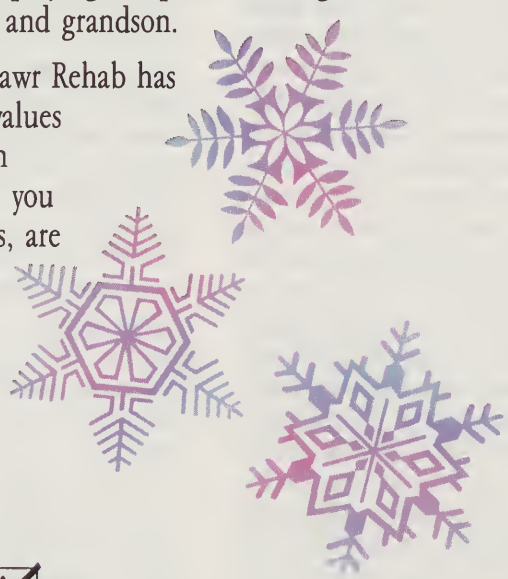
Drs. Mahmood and Rubin are affiliated with St. Joseph's Hospital and Medical Center, Paterson, and Seton Hall University School of Graduate Medical Education. Requests for reprints may be addressed to Dr. Rubin, St. Joseph's Hospital and Medical Center, 703 Main Street, Paterson, NJ 07503.

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Home Intravenous Antibiotic Therapy

Brian E. Scully, MD

Intravenous therapy for a variety of infections can be performed in the home setting; the therapy is safe and relatively cost effective. Close monitoring of the patient to ensure good care is essential. In the coming years, the variety of infections treatable at home will increase.

One of the more welcomed developments in the therapy of infection during the 1980s was the widespread introduction of outpatient intravenous (IV) antibiotic therapy, administered in the patient's home or in a clinic setting. As a result, many infections that would have required prolonged hospitalization for effective therapy, now can be managed on an outpatient basis.

A number of factors have combined to bring this about so rapidly. From the medical perspective, the new and more potent betalactams, with their attractive pharmacokinetic properties, were developed and introduced into the market. At the same time, there was an increased appreciation that the pathophysiology of certain infections, such as osteomyelitis, required the prolonged delivery of bacteriocidal concentrations of antibiotics to the site of infection to achieve a favorable outcome. From the financial perspective, there was a strong desire by hospital administrators and third-party payers to reduce costs. Lastly, many realized there was a considerable business opportunity in the provision of home care services.

The purpose of this article is to review the aspects of home care that pertain to the management of infectious diseases with particular regard to patient selection, infections and antibiotics suitable for home therapy, and problems that may be encountered in patient management.

PATIENT SELECTION

Not every patient is a suitable candidate for outpatient home IV therapy. While every case has to be considered individually, there are guidelines to patient selection:

1. The patient should be in a medically stable condition.
2. The infection should be one that is as well treated on an outpatient basis as in the hospital setting.
3. The patient should be compliant, and the patient and family member should be willing to be educated in the proper use of the equipment. The patient's personality and reliability as well as the home environment must be considered.
4. Reliable venous access should be available.

VENOUS ACCESS

A heparin lock is the preferred method of venous access in many situations. Advantages of the heparin lock are low cost, ease of insertion, and safety; the disadvantages, especially in the outpatient setting, are the need for frequent replacement and the difficulty in maintaining lumen patency. Also, because of the small calibre of the peripheral veins, the administration through heparin locks of irritant antimicrobials such as vancomycin or amphotericin B can be problematic. The administration of very dilute solutions of these antibiotics is helpful in reducing phlebitis (Table 1).

The long-term catheters, the Hickman®, Broviac®, or Groshong®, provide stable access over an extended period of time, but have their own complications (Table 2). The decision to insert one of these catheters should not be made lightly. This is particularly true in patients with prosthetic devices where a bacteremia might prove to be catastrophic and in patients with poor hygiene or extensive dermatitis where there is a high risk of infection. More recently, long-term, percutaneously inserted catheters have been developed, whereby a thin line is inserted into a peripheral vein and threaded proximally into a larger bore vein.

INFECTIONS TREATABLE BY HOME IV THERAPY

Provided the patient is stable medically, infections involving any organ system can be treated

Table 1. *Suggestions for the administration of irritant antimicrobials.*

Drug	Dilution/Administration
Vancomycin	1,000 mg in 250 to 500 cc of 0.5; normal saline infused over 2 hours.
Amphotericin B	Daily dosage: 30 mg in 500 cc of D5W + 1,000 units of heparin; infused over 4 to 6 hours. or Twice the daily dosage given on alternate days removing the catheter after each infusion.

Table 2. *Complications of long-term intravenous devices.*

A. **Early Complications**
- Pneumothorax
- Hemothorax
- Brachial plexus injury
- Air embolism

B. **Late Complications**
- Thrombosis of a central or peripheral vein and subsequent venous insufficiency
- Local infection of the exit site
- Bacteremia or fungemia l metastatic infection
- Catheter thrombosis
- Catheter tip migration
- Pulmonary embolism

with IV antibiotics in the home (Table 3). Exacerbations of cystic fibrosis, chronic lung disease, osteomyelitis, and prosthetic joint infections have been the most frequent infections treated.

Patients with cystic fibrosis and patients with chronic lung disease of a variety of types have recurrent exacerbations associated with infection. In cystic fibrosis, *Pseudomonas aeruginosa* is the most frequent pathogen. It also is not uncommon in patients with chronic bronchiectasis or bronchitis.

Effective therapy requires oral quinolones or IV ß-lactams, often in combination with aminoglycosides. Resistance may develop to any of these agents; resistance particularly is a problem with the quinolones.[1] A useful approach is to alternate treatment courses with oral and IV agents. This allows time for sensitive strains to recolonize should resistance have developed during therapy. Treatment courses should last between 10 and 21 days depending on the severity of the infection and the stage of the illness. More prolonged courses may be beneficial in some patients with end-stage disease and frequent relapses. Assuming the patient is familiar with the techniques, is not too ill, and has received the antibiotic on a previous occasion, treatment usually can be started in the home.[2,3] Alternatively, a brief hospital admission to start therapy can be planned.

In patients with bone and joint infections, there are two principles of therapy critical to a successful outcome. The first is the debridement of all devitalized tissue—necrotic bone and tendon in particular. The second is the administration of antibiotics active against the offending pathogens in amounts sufficient to achieve bactericidal concentrations at the site of infection. Finally, therapy should be prolonged so that dormant or slowly dividing bacteria will be killed.

There is an increasing realization that the second and third principles often can be met by the administration of oral antibiotics; for example, the quinolones for gram-negative bacilli.[4] However, many physicians still feel more secure with at least an initial period of IV therapy. This particularly is true where an attempt is being made to save a prothesis and in patients with associated soft tissue infection or systemic toxicity.

There also are certain problematic organisms that because of their resistance patterns, may require IV antibiotics. Examples include many strains of ß-*Pseudomonas aeruginosa*, acinetobacter, and methicillin-resistant staphylococci. There is abundant published data to support the treatment of such infections in the home setting with prolonged courses of intravenous agents.[5-7]

Most programs to treat bacterial endocarditis entail four to six weeks of IV antibiotics. Penicillin has been the mainstay of therapy but there is increasing evidence that ceftriaxone, which can be administered once daily, is equally effective as penicillin for infections due to penicillin-susceptible *Streptococcus viridans* and the Haycek group of organisms.[8,9] Home therapy, thus, has become an option for many patients.

Other infections increasingly managed at home include *Lyme borreliosis*, complicated urinary tract infections due to multiply resistant bacteria, and pelvic inflammatory disease.[10] In the latter, surgery often can be avoided if extended IV therapy is given.

Recipients of organ transplants may require extended courses of antiviral agents for cytomegalovirus or amphotericin B for aspergillus infections. If the home situation is satisfactory and the clinical conditions stable, these drugs can be satisfactorily given at home. The same applies to patients with AIDS who may have similar infections.

ANTIBIOTIC CHOICES

The most suitable antibiotics for home usage are those that have pharmacokinetic properties that allow for no more than twice daily dosing and have a low toxicity. Therefore, they do not require very close monitoring. If a peripheral vein is to be used for IV access, the drug chosen should not be irritating to the veins. Table 4 lists some of the more frequently encountered pathogens and drugs suitable to treat them.

For highly susceptible staphylococci (MIC less than 1

mcg/ml of oxacillin), cefazolin offers the convenience of eight hour dosing and low toxicity. Oxacillin is more stable to the staphylococcal ß-lactamases and would be the agent of choice to treat serious infections due to less susceptible (MIC 1 to 4 mcg/ml) strains of staphylococci. These organisms often are hyperproducers of ß-lactamase that theoretically could hydrolyze cefazolin when large numbers of organisms are present; however, the four to six hour dosing required for oxacillin is a major drawback. Recently, cartridge pumps have been developed that can obviate this problem.[11]

Vancomycin is the agent of choice for patients allergic to ß-lactams and in infections due to methicillin resistant staphylococci. It is given every 12 hours, but it is an irritant to the veins and possesses a variety of potentially serious toxicities.

For susceptible gram negatives, *Borrelia burgdorferi* and the viridans streptococci, ceftriaxone is the agent of choice because of its convenient once daily dosing, low toxicity, and efficacy.[5,6,9] Diarrhea may be encountered more frequently than with some of the other agents. This probably is related to its high biliary excretion.

Table 3. ***Examples of infections treatable by outpatient intravenous antibiotics.***

- Osteomyelitis and septic arthritis
- *Lyme borreliosis*
- Exacerbations of cystic fibrosis lung disease
- Infective exacerbations of chronic lung disease due to resistant bacteria
- Subacute bacterial endocarditis
- Prosthetic joint infections
- Cytomegalovirus infections in immunocompromised patients

For *Pseudomonas aeruginosa,* ceftazidine is preferred over the ureidopenicillins, imipenem, or ticarcillin because of its eight hour dosing schedule. Aminoglycosides are not used often at home, as they require close monitoring and are less effective than the ß-lactams due to poor tissue penetration. However, aminoglycosides sometimes are required for purposes of synergy as in enterococcal endocarditis or *Pseudomonas* pulmonary infections.

Because of the paucity of available agents, there is little difficulty in choosing between agents for viral and fungal infections. It should be remembered that ganciclovir is cleared by the kidneys and has the potential of causing serious hematological toxicity. Thus, careful monitoring is required. Acyclovir also is renally cleared. In high dosages, it may cause central nervous system side effects that often go undiagnosed. Thus, careful monitoring of this drug is required.

PATIENT TRAINING AND MONITORING AT HOME

Patients who are to receive IV antibiotic therapy, require considerable training prior to discharge from the hospital. This usually is provided by a nurse skilled in all aspects of infusion therapy prior to discharge of the patient from the hospital. The nurse may be employed by the hospital or by a home care company. The patient or family member should be taught meticulous sterile technique and the required details regarding line flushing, needle disposal,

Table 4. ***Frequently encountered pathogens, their sites of infections, and suggested therapies.***

Pathogen	Site of Infection	Suggested IV Regimen
Staphylococcus aureus *Staphylococcus,* Coagulase negative	Bone/Joint	Cefazolin 1 gm every 6 to 8 hours or Vancomycin 1 gm every 12 hours for methicillin resistant strains
Streptococcus viridans HACEK organisms	Heart Valve	Ceftriaxone 2 gms every 24 hours.
Pseudomonas aeruginosa	Lung Joint Soft Tissue	Ceftazidime 2 gms every 8 hours + Aminoglycoside, e.g. tobramycin 1.5 mg/kg every 8 hours
Enterobacter cloacae *Acinetobacter species*	Lung Bone or Soft Tissue	Imipenem 500 mg every 6 to 8 hours
Borrelia burgdorferi	Central Nervous System Joint	Ceftriaxone 2 gms every 24 hours

Table 5. *Suggested testing schedule for selected antibiotics.*

Drug	Testing Schedule
ß-lactams Acyclovir	*Weekly:* CBC, Differential Chemistry Screen.
Vancomycin Aminoglycosides	*Twice Weekly:* CBC, Differential Chemistry Screen Serum Levels—peak and trough during weeks 1 and 3.
Trimethoprim —Sulfamethoxazole Amphotericin B Ganciclovir	*Twice Weekly:* CBC, Differential Chemistry Screen.

thawing and storage of solutions, and the correct hanging of solutions. The patient also needs to be instructed as to the signs and symptoms of phlebitis and line infections. Proficiency in all aspects should be demonstrated prior to discharge.

It is critical in these days of subspecialization that a physician be clearly identified to the patient and the home care agency as being responsible for monitoring the care. Laboratory reports should be available to the physician within 24 hours of being checked. For most antibiotics, weekly testing of serum chemistries and the blood count are sufficient (Table 5). However, for selected antibiotics with the potential for serious hematological or renal toxicity, more frequent testing should be performed. It also is advisable to check serum aminoglycoside or vancomycin levels at least once during a course to ensure adequate dosing.

It strongly is recommended that the first dose of an antibiotic be given in the presence of medical or nursing personnel to detect and to treat an accelerated drug reaction, should it occur. This is not necessary in patients already hospitalized and on therapy or in some cystic fibrosis patients who may have received multitudinous previous courses of the antibiotic in question.

CONCLUSION

IV therapy for a variety of infections in the home setting is safe and relatively cost effective. A team approach providing close monitoring of the patient can ensure good care. In the coming years, it is likely the variety of infections treatable at home will increase. ■

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Dr. Scully is affiliated with the College of Physicians and Surgeons of Columbia University, New York. Address reprint requests to Dr. Scully, College of Physicians and Surgeons, Department of Medicine, 630 West 168th Street, New York, NY 10032.

Home Care for AIDS Patients

Laurie Mello-Udine, RD, CNSD

Home care is influencing the provision of care for AIDS patients by providing a cost-effective, efficacious alternative site for the delivery of care. As the number of AIDS patients and the associated health care costs increase, home care for AIDS patients will continue to expand.

As the number of cases of acquired immunodeficiency syndrome (AIDS) increases, important developments in treatment and prophylaxis have become available, including intravenous antibiotics, and antiparasitic, antifungal, and antiviral therapy. Standard therapy for AIDS can include aerosolized medications, and even parenteral nutrition (PN). Comprehensive treatment of AIDS can be costly, particularly because of hospitalizations.

In an effort to control the costs of AIDS treatment, home care has become an important option. In addition to the economic benefits, home care offers the AIDS patient increased quality of life, and reduces the burden of care for hospital personnel.

HEALTH CARE COSTS

Scitovsky reported that the lifetime cost of treating an AIDS patient ranges between $60,000 to $90,000.[1] With over 8,000 cases reported in New Jersey, the cost of treating AIDS already can be estimated at over $485 million. One way to address these rising costs has been the implementation of case management and the expanded use of home care.

In New Jersey, the AIDS Community Care Alternatives Program (ACCAP) was developed in response to the high costs of AIDS. This program is the first tax-supported program in the nation designed to meet the extensive physical and financial needs of persons diagnosed with AIDS or AIDS-related complex who meet certain income guidelines. Patients who are accepted into the program must require a minimum level of care comparable to that provided in an institutional setting. Home-based health care is utilized whenever possible to replace hospitalization.

Overall health costs run one-half to one-third of the cost of providing the same care on an institutional basis. The National Association of Home Care estimates that the average daily hospital cost for a person with AIDS is $773 compared to an average daily home care cost of $94. In addition, home care affords minimal household disruption when compared to having a family member in the hospital for long-term therapy. Given the numerous technological advances in treating AIDS-related illness, the potential for cost effectiveness, and the likely psychological benefits, the utility of home care appears obvious.

CONSIDERATIONS FOR HOME CARE

An AIDS patient may be able to remain independent for prolonged periods. Even after acute opportunistic infections, the patient may enter a recovery phase and then become stable. Often, a patient is able to return to work after recuperation.

Home care for patients without symptoms includes monitoring by a registered nurse for complications, providing emotional support, and observing tolerance to the medicines and changes in the medical condition. As the patient deteriorates and hospital admissions become more frequent, home care needs intensify. The patient and caregiver must be actively involved in the decision making for AIDS health care needs.

The use of a community support system often is beneficial to a patient in the home setting. Such programs as meal delivery, homemaker services, buddies, and spiritual support often provide the particulars that allow the patient to remain at home.

AIDS SPECIFIC HOME CARE

The immune defect caused by infection with HIV produces derangements in humoral and cellular immunity. An inverted CD4 (helper inducer T cells) to CD8 (suppressor T cells) ratio is

seen. In addition, antibody responses to antigens have been shown to be deficient. Thus, the AIDS patient is severely immunocompromised, becoming susceptible to a wide variety of infectious pathogens.

Given this broad degree of immunodeficiency, nosocomial infections also are of concern to patients with AIDS. This fact further enhances the concept of home care management as opposed to hospital management in AIDS treatment.

A major limiting factor in home care for AIDS is the development of AIDS-related dementia. The neurological disease is believed to be related to HIV-infected macrophages that release cytotoxins, thereby destroying myelin. In addition, the virus itself may disrupt the blood-brain barrier, permitting the entrance of other toxins that potentially could lead to dementia. The progression of AIDS often is accompanied by incremental dementia, cognitive changes, and neuropathies. The manifestations of these conditions often influence the ability of the patient to provide self-care, and the level of assistance and supervision needed at home.

Pneumocystis carinii pneumonia (PCP) remains the predominant infection of AIDS. Fifty to 90 percent of patients will be infected by this pathogen at some point in the course of their illness. There is a strong correlation between the baseline number of CD4 lymphocytes and the incidence of initial PCP episodes. As the CD4 count declines, PCP prophylaxis generally is instituted. The mortality rate from acute PCP currently is 14 percent.

A PCP prophylaxis regimen should be initiated in any HIV-infected individual who has endured an episode of PCP. In addition, there is general agreement that an HIV-positive patient with a CD4 cell count of less than 200 mm^3 should receive prophylaxis. Prophylaxis of PCP infection can be achieved with several drug regimens including oral TMP-SMX, and inhaled pentamidine.

Aerosolized pentamidine therapy was developed as a PCP prophylaxis regimen because of its ability to reach the intra-alveolar location of *Pneumocystis carinii.* This therapy is administered frequently in the home setting.

Actual treatment of PCP also can be accomplished at home using intravenous TMP-SMX or pentamidine. In patients with a history of sulfa allergy or severe leukopenia, pentamidine is the preferred therapy. Conversely, in patients with pre-existing renal disease, TMP-SMX is preferred. Adverse effects have been reported with pentamidine after a mean duration of therapy of 10.4 days. Pancreatitis and dysglycemia are common. In one study, 57 percent of all patients had dysglycemic reactions.

Both drugs have been administered safely in the home. However, intravenous pentamidine generally is initiated in the hospital and continued on an outpatient basis. Side effects of therapy when administered in the home can be reduced through pharmacological monitoring.

Toxoplasmosis is another protozoal infection seen in the AIDS population. Symptoms of toxoplasma encephalitis include headache, seizures, and other cognitive impairments. Pyrimethamine in combination with sulfadoxine (Fansidar®) has been used as primary treatment. The adverse reaction to pyrimethamine primarily is reflective of folate metabolism inhibition. The effect on bone marrow suppression often can be reversed by concomitant administration of folinic acid. These treatments have been successfully administered in the home environment.

The gastrointestinal tract is another important site of AIDS-related illnesses. Gastrointestinal involvement may be due to opportunistic pathogens and antigens in the intestinal lumen, as well as the underlying HIV infection itself. HIV enteropathy and the accompanying diarrhea, malabsorption, and mucosal abnormalities may exist despite the absence of any identifiable pathogenic organisms.

Cryptosporidiosis, isosporiasis, and microsporidiosis are common parasites resulting in AIDS enteritis. These organisms may be clinically indistinguishable in their presentation with symptoms of diarrhea, abdominal cramping, and weight loss.

Home treatment regimens have included hydration therapy and PN support through the acute diarrheal episodes. Octreotide acetate (Somatostatin®) injections reduce stool volume and produce symptomatic relief. Isosporiasis has been treated successfully with TMP-SMX for one week. Microsporidiosis has been treated experimentally with metronidazole with some success in improving symptoms but not eradicating the parasite. Treatment for cryptosporidiosis remains illusive, but trials of spiramycin continue.

Another common infection in AIDS patients that can be managed with home care is cytomegalovirus (CMV). Ninety percent of AIDS patients at biopsy have evidence of CMV, however, only 25 percent of patients experience life-threatening CMV infections. CMV may present as retinitis with progressive visual loss. It also may present as a disseminated infection with symptoms of fever, weight loss, fatigue, and ulcerations in the esophagus, stomach, or duodenum.

Therapy of CMV often includes intravenous administration of ganciclovir. After induction therapy (5 mg/kg twice a day for 14 days), long-term maintenance therapy usually is recommended. Since ganciclovir may only suppress and not eradicate the virus, lifetime therapy may be necessary.

Thirty percent of patients receiving ganciclovir develop adverse reactions including neutropenia. When neutrophils fall

below 1000/mm^3, the therapy often is withheld and reinstituted when the counts improve.

Long-term therapy with ganciclovir can be administered safely through a central venous catheter at home. The patients can be taught sterile preparation and reconstitution of the product and its administration.

Other intravenous antivirals also have been administered successfully at home. Intravenous Foscarnet® has been used in the home setting for the treatment of CMV, as well as for acyclovir-resistent herpes infections. Intravenous acyclovir has been used in the home to treat resistent herpes infections.

Mycobacterium avium intracellulare (MAI) symptoms are nonspecific with fever, malaise, and weight loss. MAI is the most common mycobacterial species found in AIDS, however, tuberculosis with lymphatic and central nervous system involvement also is seen and treatment is similar to that in non-AIDS of isoniazid: rifampin:ethambutol. MAI has not been shown to be responsive to any one regimen, however, various combinations have been tried including rifampin, ethambutol, and amikacin administered intravenously. Again, these treatments can be administered in the home along with symptomatic support with hydration and/or PN.

The pathogenesis of AIDS wasting syndrome remains unclear; however, a decrease in oral intake due to *Candida,* anorexia, and/or side effects of drug therapy is apparent. AIDS enteropathy with concurrent malabsorption also is evident, and reports of malabsorption even without diarrhea have surfaced. Weight loss in AIDS patients can reach 40 to 50 percent of usual body weight. Although described previously as irreversible, patients with HIV wasting syndrome can be nutritionally supported with success. Nutritional support along with proper medical therapy can optimize quality of life. Both enteral nutrition and PN have been used as long-term home therapy in patients with severe weight loss.

Home chemotherapy has been utilized to treat malignancies including Kaposi's sarcoma and lymphomas. The administration of blood products in the home also is on the rise in the AIDS population. The advent of controlled analgesia infusion systems has allowed an increased usage of pain management as well.

CONCLUSION

The home care needs of the AIDS patient are diverse. Due to the intensity of care that often is required, an integrated approach with the input of many disciplines is necessary. Nursing visits to the home often are required more frequently as the patient deteriorates.

The roles and responsibilities of the home care nurse include monitoring the patient's physical and psychological status, patient and caregiver education, and communication with the primary physician and other health care providers. Social work, nutrition, pharmacy, and rehabilitation services cannot be overemphasized.

It is imperative that the patient be the decision maker regarding all aspects of care. The decision may include consent for treatment initiation and/or continuation, and preference for home management.

The numbers of patients with HIV infection who will require home care is increasing. Primary care physicians play an integral part in assessing the suitability of the patient and therapy for the home setting. Also, the primary physician provides support for the patient and caregiver, and support and direction for the home health care team. ■

Ms. Udine is a registered dietitian. Requests for reprints may be addressed to Ms. Udine, Clinical Home Care, 70 New Dutch Lane, Fairfield, NJ 07004.

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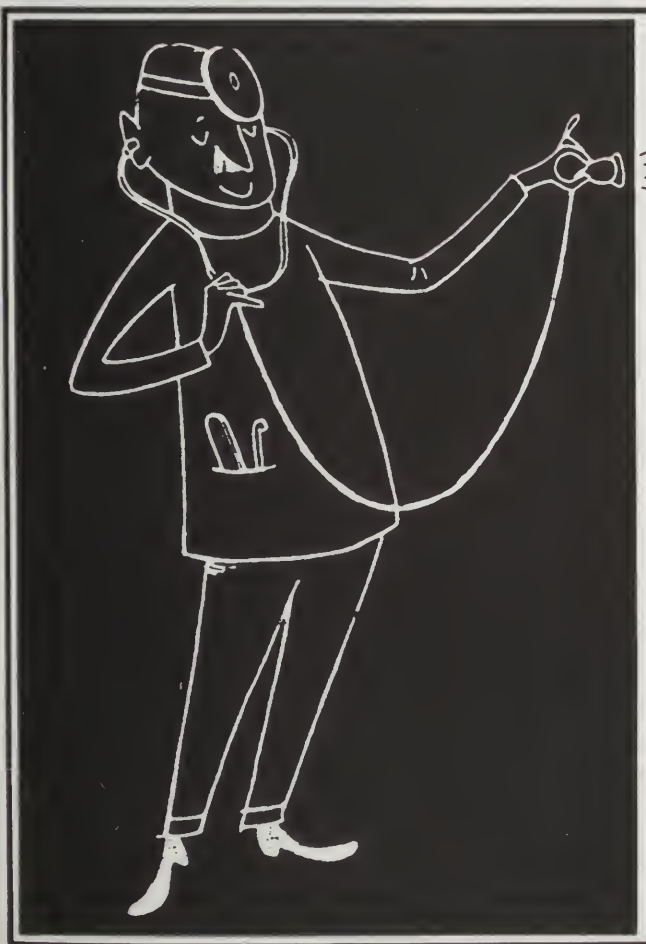
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Home Health Care: Intravenous Gamma Globulin

Leonard Bielory, MD

The use of intravenous immunoglobulin (IVIG) has been expanding to include a variety of immunodeficiency, autoimmune, and inflammatory disorders. Several researchers have demonstrated home administration of IVIG is economically feasible and safe.



Intravenous immunoglobulin (IVIG) therapy is a method of treating immunodeficient patients or patients with autoimmune disorders.[1-3] Immunoglobulins, also known as antibodies, are composed of proteins produced by cells of the B-lymphocyte lineage and are the major effector molecules of the humoral immune system with two major functions: to bind antigen and to interact with host tissue. Immunoglobulins of the five major classes (IgM, IgG, IgA, IgD, and IgE) differ from one another in structure and function. Although antibodies can be specific for the same antigen, the specificity of a given antibody molecule is unknown.

Individuals lacking the humoral portion of the immune system commonly develop chronic infections, i.e. bacterial and viral, along portions of the mucosal system, e.g. sinusitis, bronchitis, pneumonia, gastroenteritis, with significant morbidity and mortality.[4] Congenital immunodeficiency diseases may result from deficiencies in the number or function of any component of the immune system. Primary immune deficiencies, i.e. disorders of lymphocyte differentiation, and secondary immune deficiencies, e.g. severe burns, lymphoma, and chronic lymphocytic leukemia, decrease the patient's ability to synthesize one or more classes of immunoglobulins and are associated with an increased incidence and severity of infection.

The original treatment of humoral deficiencies was aimed at the replacement of antibodies using whole plasma while immunoglobulin preparations isolated from the serum globulin fraction were first isolated and used in clinical medicine in 1952.[5] These early preparations were available only in an intramuscular form and were severely limited by the volume of the injection. Subcutaneous infusion of the intramuscular preparations were used to deliver larger amounts during the course of a month, but required daily infusions and were uncomfortably cumbersome.[6] IVIG was introduced in the United States in 1969, but did not make an impact until 1981, when a reduced and alkylated product with a half-life of 21 days was introduced. This product was a chemically modified antibody preparation that was well tolerated when injected intravenously.

IVIG preparations are plasma derived from healthy human donors whose blood has been screened for hepatitis B virus and HIV antibody. Studies have demonstrated that the cold ethanol extraction procedure used in the isolation of a plasma fraction enriched for IgG antibodies, inactivates the human immunodeficiency virus. No cases of hepatitis B or HIV infections have been associated with any IVIG product licensed in the United States.[3] Because IVIG is collected from plasma pools, there is a broad range of antibody specificities to bacteria, viruses, and fungi. IVIG is largely IgG (greater than 90 percent) with trace amounts of IgM and IgA. IVIG represents an important treatment for immune deficient patients, since it provides antibodies that increase the ability to fight invading microorganisms. Currently, six IVIG preparations are licensed for administration in the United States:

Gamimune N® (Miles/Cutter), Gammagard® (Hyland Division, Baxter Therapeutics), Iveegam® (Immuno U.S.), Sandoglobulin® (Sandoz), American Red Cross® (Hyland), and Venoglobulin I® (Alpha).

A recent National Institutes of Health Consensus Development Conference concluded that IVIG was the accepted standard in clinical practice for replacement therapy of patients with primary immunodeficiencies. Effective IVIG regimens also have been developed for the treatment of acute idiopathic thrombocytopenic purpura and Kawasaki's syndrome. Recently, IVIG has been used in the treatment of diseases such as pediatric AIDS, infections in low birth weight infants, bone marrow transplants, rheumatoid arthritis, and myasthenia gravis. However, additional data are needed to confirm the efficacy of IVIG as a therapeutic adjunct in these diseases.[3]

IVIG is available in liquid or lyophilized powder form. Lyophilized IVIG products must be reconstituted with the appropriate volume of sterile diluent that accompanies the product. Liquid IVIG products must be refrigerated and allowed to warm to room temperature before infusion. Most lyophilized IVIG preparations can be stored at room temperature up to 77°F and intravenous administration is most safely completed within six hours after reconstitution.

The incidence of adverse reactions associated with the administration of IVIG as reported by the manufacturers is in the range of 1 to 15 percent, but usually less than 5 percent. Common side effects of IVIG can include headache, fever, backache, nausea, vomiting, chills, and fatigue. Reactions can occur within the first 30 minutes or at the end of the infusion and continue for several hours afterward, but usually are self-limiting. These reactions generally can be decreased or eliminated by temporarily stopping or decreasing the infusion rate. Premedication with acetaminophen or an antihistamine may be helpful. Infrequently, severe, life-threatening reactions can occur, such as chest pain, hypotension, bronchospasm, laryngeal edema, and shock. Emergency equipment and medications including epinephrine should be immediately available in the event a severe systemic reaction should occur. Patients with primary immunodeficiencies are more likely to experience side effects during initial IVIG infusions than are patients with secondary immunodeficiencies or autoimmune disorders, e.g. idiopathic thrombocytopenic purpura and Kawasaki's disease. Patients with IgA deficiency have an increased risk of adverse effects during IVIG infusions due to the presence of class-specific, i.e. IgE, antibodies to IgA in 40 percent of patients.[7] If a plasma product containing IgA is inadvertently administered, e.g. red blood cell transfusions, platelet transfusions, fresh frozen plasma, a severe anaphylactic reaction could occur. Since commercially available IVIG preparations contain various amounts of IgA, it is recommended that the IVIG preparation with the lowest IgA concentration, i.e. Gammagard®, be given to patients with selective IgA deficiency requiring IVIG replacement.

IVIG therapy predominantly has been utilized in teaching hospitals due to the referral for tertiary evaluation of an underlying immunodeficiency or in experimental treatments of autoimmune conditions. The considerable expense is a factor limiting the wider use of intravenous immunoglobulin. An adult dosage of 200 mg/kg (the lowest monthly maintenance dose in most hospital settings) costs about $600, excluding costs for administration. However, the expense is rapidly recouped, if a single hospitalization for a serious bacterial infection is prevented per year. In order to further decrease the overall cost of IVIG, outpatient and home infusions by trained professionals are economically preferable, safe, and convenient for selected patients.

In a comparative study of patients receiving other biological materials, i.e. factor VIII replacement therapy for hemophilia, less than 10 percent were using some type of home therapy. One explanation has been the lack of published data on the hazards or deficits of home therapy. In a recent study performed in Boston, there was a dramatic decrease (from 90 percent to 13 percent) in the complication rate associated with hemophilia when these patients started home therapy regimens.[8-10] In addition, there was a 40 percent decrease in cost of treatment (from $213,900 to $129,000 in 72 patients). The added benefit of improved school attendance in the pediatric population receiving home therapy of factor VIII for hemophilia could be extrapolated to the adult population in decreasing work absenteeism.[11]

Patients with primary hypogammaglobulinemia require immunoglobulin replacement therapy for the rest of their lives. During the era of intramuscular gamma globulin, injections were weekly and the dose given by this route was limited. In addition, patient compliance was poor due to the painful injections and increased side effects.[12] The advent of IVIG with fewer side effects also has enabled larger doses to be given less frequently.[1,4] This provides the basis of giving infusion safely at home similar to the therapy used for hemophiliacs who have utilized factor VIII infusions at home for over 20 years.

There is a vast reservoir of motivated manpower among families of patients with humoral deficiencies as manifested in the dedication of the support groups organized by the Immunodeficiency Foundation. Previous studies with patients receiving factor deficiency and a few studies of IVIG suggest that the day-to-day aspects of managing

chronic illness can be handled safely at home by a properly educated patient and family.[13-18] In fact, for hemophilia, the results seem clearly superior to those of traditional physician-administered health care delivery systems. Such considerations gain added importance with the present state of overloaded ambulatory health care facilities.[19]

CONCLUSION

The advent of IVIG, enabling larger doses of immunoglobulin to be given less frequently with fewer side effects,[1,4] brings it into line with other home therapeutics such as biologicals, i.e. factor VII for hemophiliacs, hyperalimentation, antibiotics, and chemotherapy.

Patients being treated with parenteral gamma globulin therapy for immunodeficiencies clearly may benefit from home infusions. However, prospectively performed clinical studies of IVIG administered at home are required to establish clinical protocols for monitoring quality assurance issues, evaluating cost effectiveness, assessing the medicolegal issues, and examining health status and morale. ■

Dr. Bielory is a member of the Editorial Board of *NEW JERSEY MEDICINE*. He is affiliated with the Department of Medicine, UMDNJ-New Jersey Medical School. This paper was supported in part by an educational grant from Sandoz Pharmaceutical Corporation and Protocare, Inc. Requests for reprints may be addressed to Dr. Bielory, UMDNJ-New Jersey Medical School, 185 South Orange Avenue, MSB E-583, Newark, NJ 07103-2714.

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Home Infusion for the 1990s: A Patient's Perspective

Fran L. Freeman

Home infusion therapy gives patients a great degree of control over their lives. Although adjustments are needed to follow the prescribed infusion therapy, these changes are minimal when compared to hospitalization. With social and technical support, patients will choose home infusion therapy.



Home infusion of total parenteral nutrition (TPN) has liberated hundreds of patients from hospital confinement. It is a relatively common modality used in several chronic and in some time-limited illnesses. For the patient with a nonfunctional intestinal system, it may be the only real chance at a normal life. Quality of life can be greatly enhanced for such individuals who would otherwise face protracted hospitalization.

TPN first was applied in hospitalized patients over 20 years ago. This treatment has progressed to the point where it can be easily handled in the home setting. Intravenous supplies and materials are delivered to the patient by the home care therapy provider. The patient connects himself to the infusion using sterile techniques and basic precautions.

Were it not for the availability of numerous home care companies, such an effort might easily overwhelm the average person. These companies provide various levels of support, ranging from the provision of pre-mixed solutions and supplies to comprehensive care including nursing services. The patient may have left the hospital, but he still is connected to a medical system that is able to respond quickly and appropriately to his needs.

Home infusion therapy also has advanced significantly. In its early days, a home care patient was required to perform a complete home mixture of parenteral nutrition. Some patients even were given a small laminar flow hood for use at home. Most patients no longer have to mix solutions, as advances in techniques now allow for longer periods of stability of the formula. However, some patients still add one or two ingredients to their home TPN bag before use.

TRAINING AND PRACTICE

The process of training a person for home infusion involves learning a comprehensive model. However, these techniques can be learned after two or three training sessions; much depends on the teaching and communication skills of the home care nurse.

The patient must be able to understand very thorough verbal, hands-on, and written instructions from the nurse. An instruction booklet with step-by-step illustrations becomes the patient's bedside companion. During the teaching process, the patient must be able to demonstrate technical skill to the nurse, first with a model and then with his actual catheter.

Daily home nursing visits are made until the patient is confident with the home infusion process. The nurse then certifies that the patient can manage various techniques on his own. At that point, nursing visits can be decreased to once a week or less, although a nurse should continue to be available 24 hours-a-day for problems and emergencies.

The prospect of performing these procedures for oneself is initially somewhat intimidating. However, the sense of independence gained is a very positive benefit, especially for a person with a chronic illness. For a patient who has undergone repeated hospitalizations, home care is a welcome relief. After months of dealing with doctors,

nurses, and technicians, the patient finally is free to make some of his own decisions.

Despite this newfound independence, a patient does rely on his home care nurse. The nurse should be available to answer the many questions that arise during the course of therapy. It also is important that the nurse periodically recheck the patient's techniques, and certify his adequacy.

The time commitment for TPN is minimal once the technical procedures become routine. For example, a dressing change generally takes only five to ten



minutes. Similarly, the startup time for an infusion takes about three to five minutes. An experienced, trained patient prepares all the needed supplies beforehand. This minimizes the "hassle factor" and prevents surprises.

Home infusion therapy also complicates some seemingly simple everyday tasks, so good organization is necessary. For example, planning for one or two nights away from home requires much attention to detail in order to make sure that essential supplies are not left behind, and that there will be adequate refrigeration for medications and solutions. Long distance trips require that arrangements be made in advance so the patient will know what to do and whom to call in an emergency. The home care company can be very helpful in this regard. It usually has contacts throughout the country and very quickly can ship supplies and solutions anywhere.

The use of a portable pump can make a big difference between whether the patient feels trapped or free. The portable pump gives a measure of freedom that cannot be achieved when using a larger pump on a pole. Such freedom of movement can make a tremendous difference in morale by maximizing flexibility and control for the patient.

SOCIAL ISSUES

Emotional support and encouragement from family members, friends, and health care providers is essential. Home infusion therapy, while not technically difficult, can be very stressful. This may compound the emotional effort of dealing with one's illness and family.

Sometimes friends and relatives are unsure of how to deal with the patient concerning his therapy. This may be a first encounter with intensive home care. Since infusion therapy has been long associated with the hospital setting, it has a stigma of serious illness. Social interactions may be strained by this set of circumstances. Most people are unprepared to deal with the concept of chronic illness.

Similarly, the patient may need to talk about the change in his lifestyle but may be reluctant to raise the issue with friends or colleagues. This certainly is true in the workplace where social interactions are expected to occur with some degree of professional distance. Employers need to understand the patient's special needs but one does not want to be viewed as "limited" or troublesome. A mistaken confidence might affect longevity or promotional opportunities.

The home care nurse can be very helpful in this regard since he is a "safe" person with whom to talk. Through the nurse, the patient can benefit from the experience of others. By relating how other individuals using home infusion therapy have dealt with these problems, the home care nurse also functions as a social worker. This process often translates into new insights for the patient. More importantly, a patient will realize he is not alone.

The recent development of self-help groups and organizations is a welcome factor in dealing with the psychosocial aspects of home infusion. National organizations such as the Oley Foundation and the National Foundation for Colitis and Ileitis provide newsletters and telephone numbers a patient can use to learn more about his illness. Local and national meetings provide the opportunity to share feelings with people who have been through the experience.

The number of social activities that revolve around eating becomes very apparent once TPN begins. While a patient is not typically hungry on TPN, he might miss eating, creating a "will power" problem. Friends feel uncomfortable when eating around the TPN patient and feel a need to protect the patient from his desire to participate in the meal.

The most difficult of the social aspects occurs around the issue of dating. This especially is true when dealing with new acquaintances. Whether to inform people right away or to conceal the problem is a real dilemma. Withdrawal from certain social situations can occur in an attempt to protect oneself from rejection.

LIFESTYLE

The use of TPN and the concomitant lifestyle changes that occur can help to reorder one's priorities. The patient's schedule must be reoriented to include the time for infusion.

A patient can infuse his TPN overnight while sleeping. In this method, interruptions of work and social activities are minimized. However, the quality of sleep may be affected. The "feel" of the tubing and the sound of the infusion pump are foreign to a person's ordinary bedtime routine.

A patient could choose to infuse during the day via a portable

pump. This eradicates the concern over sleep deprivation but adds the possibility that a patient will have to take time from other activities to monitor the infusion. It also requires the patient carry five to ten pounds of equipment and solutions.

Leisure time becomes very important. This is time not only free from work but also from the effort of home infusion. One must remember that the reason for all the effort is to enjoy more of life.

Managing a career, TPN, and a chronic illness requires flexibility. Alternative work schedules can be helpful. Recently, the development of minicomputers has added the ability to do some of one's work at home. Every effort should be made to allow the patient to adapt to his existing employment. The implications of changing to a new job include new pressures and stresses, a possible loss of flexibility, and a possible change in insurance benefits. With rapidly increasing health insurance costs, many employers are cutting back in various ways, including the addition of pre-existing condition clauses and lifetime maximums. This can be a serious issue and can even preclude new employment opportunities if alternate coverage is not available.

CONCLUSION

Home infusion therapy gives a patient a great degree of control over his life. This would not be possible in an institutional setting. Although adjustments are needed to follow the prescribed infusion therapy, these changes are minimal when compared to the prospect of prolonged hospitalization. As long as adequate social and technical health care supports are available, home infusion therapy is the patient's treatment of choice. ■

Ms. Freeman has been a home TPN patient for three years. Address reprints requests to Ms. Freeman, c/o Dr. Michael Rothkopf, 124 East Mount Pleasant Avenue, Livingston, NJ 07039.



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A one-night deposit (equivalent to room rate) is required with all reservation requests. Please send check or money order payable to the **TRUMP TAJ MAHAL CASINO/RESORT** or complete the following:

Card # _____ Type _____ Exp. Date _____

SCHEDULE OF RATES SUBJECT TO 13% TAX
☐ SINGLE **$115** ☐ DOUBLE **$115** *(Reservations must be received prior to April 2, 1992)*
Extra Person **$25**
☐ One-Bedroom Suite **$275 per day**
☐ One-Bedroom Hospitality Suite **$300 per day**

Check-out time is 12 Noon. Rooms may not be available for check-in until after 3 p.m. Check-in time on Sundays is 5 p.m. FORTY-EIGHT (48) HOURS NOTICE OF CANCELLATION is required for a full refund.

PARKING: FREE PARKING TO REGISTERED GUESTS. One car per room.

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****

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Trump Taj Mahal Casino/Resort
1000 Boardwalk at Virginia Avenue
Atlantic City, New Jersey 08401
Tel: **1/800/825/8786**

DOCTORS' NOTEBOOK

TRUSTEES' MINUTES

A regular meeting of the Medical Society of New Jersey Board of Trustees was held on November 17, 1991. Detailed minutes are on file with the secretary of your county society. A summary of significant actions follows.

President's Report. Noted the following items: the need for more dialogue, better communication, and a good working relationship with state legislators; appreciation for the opportunity to address UMDNJ faculty; lack of discrimination in New Jersey regarding licensing of graduates of qualified international medical schools; and recommendations by the New Jersey Obstetrical and Gynecological Society and the New Jersey State Department of Health to perform HIV testing on all women who are pregnant or are contemplating pregnancy.

Executive Director's Report.

1. MSNJ Financial Statements. Reviewed and approved MSNJ's financial statements for the period ending October 31, 1991.

2. State Board of Medical Examiners (SBME)—Litigation. Noted the following: SBME versus Sinha: petition for certification to the Supreme Court is pending; physician assistants regulation: briefing process in the Appellate Division has been completed; and biennial licensing renewal: decision is expected in early January 1992.

3. Brachfeld versus Medical Inter-Insurance Exchange (MIIX). Discussed this case noting: an explanatory mailing was completed; a significant number of physicians have elected not to be a plaintiff in the class action; and the necessity to reinforce the performance of MIIX.

4. Medicare Resource-Based Relative Value Scale (RBRVS). Noted the following: effective January 1, 1992, payments for physicians' services under the Medicare program will be based on a national fee schedule; fees considered inequitable should be called to the attention of the AMA by state and/or specialty societies; educational programs for physicians and office staffs will be sponsored by Pennsylvania Blue Shield; actions of the American Medical Association House of Delegates will be presented at the December meeting of the MSNJ Board.

5. New Medicaid Fiscal Agent: Unisys. Reviewed the information that the transition to the new Medicaid fiscal agent, Unisys Corporation, is in progress and physicians need to verify the information on the Unisys provider file and note their newly assigned seven-digit Medicaid number.

6. Special Meeting. Announced a special dinner meeting of the MSNJ Board of Trustees, the New Jersey State Medical Underwriters Board of Directors, and MIIX Board of Governors to be held for the three groups on January 8, 1992.

University of Medicine and Dentistry of New Jersey. Received for information, the report of UMDNJ.

NJ Hospital Association (NJHA) Report. Heard a brief report from Fred M. Palace, MD, MSNJ's liaison to NJHA highlighting that the recent election proved health care is a sensitive but important issue.

MEETINGS OF THE BOARD OF TRUSTEES of the Medical Society of New Jersey

January 19, 1992
February 9, 1992
March 15, 1992
April 15, 1992

Meetings of the Board of Trustees are open to all physicians. The meeting on March 15, 1992, is an OPEN FORUM, to allow physicians the opportunity to stand up and be heard. If you would like to attend the OPEN FORUM, please contact Diana Gore, MSNJ headquarters, 609/896-1766.

NJ State Nurses Association (NJNA). Discussed the following items: the desire to strengthen the relationship between MSNJ and NJNA; William E. Ryan, MD, was the MSNJ representative at the NJNA Annual Convention; and position statement on HIV advocates universal precautions, strict infection control procedures, and intensive education.

State Board of Medical Examiners (SBME). Was informed that there are three current vacancies on SBME.

Committee on Maternal and Child Care. Approved implementation of the Obstetrical Review Plan (to evaluate and maintain quality of perinatal care).

Committee on Membership Services. Approved the following recommendation:

That the Medical Society of New Jersey endorse the Affinity Fund, Inc., as a provider of long distance telephone service for the membership.

Also, did not approve the following recommendation:

That the Medical Society of New Jersey endorse the Credit Information Service program offered by Doctor Melvin L. Schulman and Donald F. Smith & Associates.

Council on Public Health. Returned to the Committee on Environmental Health for further study the following two recommendations submitted by the Committee:

That the State Department of Environmental Protection and Energy establish emission standards for heavy metal air pollutants, based upon their impact on health.

That the State Department of Environmental Protection and Energy establish standards for mercury, based upon their impact on health.

New Business.

1. PRO (Peer Review Organization) Requirement for History/Physical for All Surgery Patients. Will forward a request to the American Medical Association to petition the Health Care Financing Administration to decrease (from 25 points to 1 point) PRO's citations for physician's previous failures to provide history and physical data on surgery patients.

2. New Conscious Sedation Amendment to NJAC 8:43G-6. Noted that MSNJ would seek a corrected interpretation of *NJAC 8:43G-6* from the New Jersey State Department of Health, allowing registered professional nurses to administer conscious sedation supplementally; revised guidelines stated that a registered professional nurse may administer supplemental dose or doses of conscious sedation if certain requisites are met.

3. Medical Fee Schedules: Automobile Insurance PIP Coverage. Voted to support the proposed amendments that define the rules for multiple surgical procedures, as compared to physical therapy; the need for amendment evolved from the application of multiple surgical procedure reimbursement concepts to physical therapy reimbursement by several insurance carriers. □

1992 MSNJ Annual Meeting Proposed Daily Schedule

Saturday, May 2, 1992

3:30 p.m. Board of Trustees' Meeting

Sunday, May 3, 1992

8:00 a.m. Registration Opens
9:30 a.m. Message Center Opens
10:00 a.m. Educational Program
11:30 a.m. Exhibits Open
2:00 p.m. House of Delegates
3:30 p.m. Reference Committee Meetings

Monday, May 4, 1992

8:00 a.m. Registration Opens
8:00 a.m. Message Center Opens
8:30 a.m. Exhibits Open
9:00 a.m. House of Delegates (Election)
12:00 noon Golden Merit Award Ceremony and Reception
2:30 p.m. Reference Committee Meetings
5:00 p.m. JEMPAC Political Forum
5:45 p.m. JEMPAC Wine and Cheese Reception
6:30 p.m. Camden County Medical Society Reception

Tuesday, May 5, 1992

8:00 a.m. Registration Opens
8:00 a.m. Message Center Opens
8:30 a.m. Exhibits Open
9:00 a.m. House of Delegates
1:30 p.m. House of Delegates
2:00 p.m. Exhibits Close
7:00 p.m. Inaugural Reception and Dinner

Wednesday, May 6, 1992

8:00 a.m. Registration Opens
8:00 a.m. Message Center Opens
8:30 a.m. General Session (Educational Program)
1:00 p.m. Board of Trustees' Meeting

MSNJ AUXILIARY

Campaign '92 is underway and the Auxiliary is encouraging physicians and their spouses to become actively involved in what may prove to be the most important election of the century. On November 3, 1992, American citizens will have the right to vote for a president, 35 United States senators, 435 congressmen, 12 governors, and thousands of state and local officials. Many Auxiliary members already have joined the AMA in its "Participation '92"—a nationwide effort to interest medical families in the national, state, and local political campaigns and to urge its members to attend Republican and Democratic conventions as delegates or alternates. Hopefully, members of the entire medical community will use the opportunity to make their voices heard!

The Auxiliary also is involved in a campaign to raise funds for the American Medical Association–Education and Research Foundation (AMA-ERF). Until March 9, 1992, members will be selling $100 tax-deductible raffle tickets on a Mercedes-Benz 190E with a consolation prize of a four-night Caribbean cruise for two. Only 600 tickets will be sold and the drawing will be held in Lawrenceville on March 9, 1992. Funds raised from the event will enable medical schools to purchase much-needed equipment for projects, provide funds for research programs, and give financial assistance to medical students. The MSNJ Auxiliary is proud to be part of the nationwide effort that raises over $2 million annually for AMA-ERF.

Finally, the Auxiliary is campaigning to increase membership by 10 percent. It is particularly reaching out to the career spouse—male and female. Latest figures from the AMA Auxiliary indicate that the number of men joining the Auxiliary is growing significantly. There presently are 2,758 male members—a sizable increase since 1989 when men accounted for 1.35 percent or 962 members of the total membership. The increase in male participation is due in part to the ever-increasing number of female medical school graduates and the desire on the part of men to contribute their expertise to both legislative and health-related activities in the community. To qualify for membership in the Auxiliary, one must be the spouse or unmarried son or daughter of a member, or eligible member of the AMA or state or county medical society. ☐ Marion H. Geib

UMDNJ NOTES

UMDNJ gains federal grant to study CFS. A four-year, $2.1 million federal grant has been awarded to UMDNJ, New Jersey's university of the health sciences, and an affiliate hospital to establish a joint research center to study chronic fatigue syndrome (CFS). The center is a joint project of UMDNJ-New Jersey Medical School, Newark, and Veterans Administration Medical Center, East Orange. The grant is from the National Institutes of Health, which is funding only three CFS centers nationwide.

The new CFS center will offer patients both clinical treatment and the opportunity to be a part of the new research studies, according to Dr. Benjamin Natelson, professor of neurosciences and coordinator of the project.

Hispanic Center of Excellence. A federally funded Hispanic Center of Excellence, one of seven in the nation, has been established at UMDNJ-New Jersey Medical School, Newark. The Center was created to increase the number of Hispanic medical students and faculty at the medical school. It is funded by a three-year $700,000 grant from the federal Department of Health and Human Services.

Over the next three to four years the Center's goals are: to increase the number of Hispanic applicants by 50 percent; to double the enrollment of underrepresented Hispanic students; to assure that matriculated Hispanic students graduate and become licensed physicians; to increase the number of Hispanic faculty and foster their progression to senior, tenured positions; and to establish a resource center for Hispanic health care issues.

New pediatric AIDS facility dedicated at Children's Hospital. Countess Albina du Boisrouvray, a major benefactor of UMDNJ's pediatric AIDS programs in Newark, was the guest of honor at the dedication of a new pediatric AIDS facility. The facility is a joint project of UMDNJ-New Jersey Medical School and Children's Hospital of United Hospitals Medical Center, Newark, where it is based. The facility will house four programs: the federally funded AIDS Clinical Trials Unit; the National Pediatric HIV Resource Center; the Francois Xavier Bagnoud International Training Program; and the Children's Hospital AIDS Program.

Researcher boosts mental capacities of brain-damaged infants. Researchers at UMDNJ-Robert Wood Johnson Medical School, New Brunswick, have developed a method to restore the mental capacities of brain-damaged premature infants. Dr. Michael Lewis, professor of pediatrics, discovered that an infant's environment often determines whether brain damage suffered at birth will be permanent. He also found that intellectual development can be enhanced by computer-assisted intervention techniques at home. The U.S. Department of Health and Human Services awarded a $78,520 grant to help support Dr. Lewis's research.

Researchers develop driving

tests for brain-injured patients. Rehabilitation specialists are developing new standardized automobile driving tests for brain-injured patients to evaluate more accurately if these patients can safely take the wheel again. Researchers at UMDNJ-New Jersey Medical School and Kessler Institute for Rehabilitation, East Orange, are devising written and behind-the-wheels tests to better determine the driving ability of patients who have sustained strokes or head trauma.

The goal of the research is to create a prototype evaluation that tests the exact skills needed to drive. Dr. Thomas Galski, assistant professor of physical medicine and rehabilitation at the medical school and director of psychology and neuropsychology at Kessler Institute, a UMDNJ affiliate, heads the study.

The behind-the-wheels test, which includes 26 tasks, also is being modified by the researchers.

A comprehensive system of testing—including written tests, a driving simulator, and on-the-road testing—is being developed to predict safe driving. The main advantages are that the evaluations will pinpoint areas of deficiency before the patient gets behind the wheel and they will allow for training in safe driving. This approach will enable therapists to work on each patient's specific weaknesses.

Dr. Duvoisin receives Motolinsky Award. Dr. Roger C. Duvoisin, internationally known Parkinson's disease expert, is the recipient of the Motolinsky Foundation's Distinguished Service Award. Dr. Duvoisin, William Dow Lovett Professor of Neurology at UMDNJ-Robert Wood Johnson Medical, is the 17th recipient of this award presented annually by the Melvyn H. Motolinsky Research Foundation. Dr. Duvoisin was honored for his pioneering efforts in the study of Parkinson's disease. □
Stanley S. Bergen, Jr, MD

AMNJ REPORT

The Board of Trustees of the Academy of Medicine of New Jersey (AMNJ) has named the 1992 recipients of the awards that will be presented at our Annual Awards Dinner on Wednesday, May 27, 1992, at the Chanticler in Short Hills.

Frederick B. Cohen, MD, of South Orange will receive the Edward J. Ill Award "presented annually to that physician of New Jersey who merits recognition by the Academy for distinguished service as a leader in the medical profession."

Dr. Cohen has been director of the Division of Medical Oncology at Newark Beth Israel Medical Center since 1970. He has served the medical community of New Jersey as a premiere consultant in oncology and as an active participant in state and national affairs. His extensive contributions to the New Jersey Division of the American Cancer Society led to his election as president from 1985 to 1987; he has served on their Board of Trustees since 1981. In 1983, he was appointed by Governor Kean to the New Jersey State Commission on Cancer Research and was appointed chairman in 1985. He was the first chairman of the Cooperative Oncology Group of New Jersey and is active in clinical cancer research. Dr. Cohen served as president of AMNJ from 1989 to 1990 and as chairman of the MSNJ Committee on Publication from September 1985 to August 1988. He currently serves on the Editorial Board of *NEW JERSEY MEDICINE.*

The Academy's Citizen's Award is "presented annually to that citizen or group of citizens of New Jersey who merit recognition by the Academy for distinguished service in the interest of the health and welfare of the community at large." The 1992 Citizen's Award has been granted to Dr. Elizabeth Boggs of Hampton.

Dr. Boggs is a scientist, historian, and author and is known as the "First Lady" of the national Association for Retarded Citizens (ARC). ARC is a parent advocacy group she helped found in 1950. In the late 1960s, she invented the phrase "developmental disabilities" to distinguish mental retardation from mental illness and to unify advocates of people with various disabilities and birth defects that appear in the developmental years, as opposed to later in life. A resident of Hunterdon County, she donated land for the construction of a group home where developmentally disabled people could learn the latest techniques in independent living. She was also responsible for the wheelchair ramp concept that now is law for public buildings.

In addition, Roger Moore, MD, was elected to the Board of Trustees of AMNJ. Dr. Moore will complete the term of Stanley Leonberg, MD, who is recovering from an accident. Dr. Moore presently is cochairman of the Department of Anesthesiology at Deborah Heart and Lung Center, Browns Mills. Also, he is president of the Burlington County Medical Society and is the immediate past-president of the New Jersey State Society of Anesthesiologists.

AMNJ's Board recently approved a Publications Committee recommendation that we encourage further cooperation between speakers at AMNJ section and specialty society meetings and *NEW JERSEY MEDICINE.* The Committee's chairman, Alan Lippman, MD, will send a communication to Academy section chairmen and the presidents of affiliated specialty societies suggesting that manuscripts based upon presentations at these meetings be published in the state medical journal. A followup procedure will be implemented as well.

AMNJ was funded by the New Jersey State Department of Health, Division on Aging to develop and implement a new roving symposia series for medical problems in the elderly. Morris Green, MD, PhD, is the chairman of this program. The slides and an accompanying outline have been completed and are available to lecturers in the series. Lectures are available at no cost to requesting hospitals. AMNJ presently is recruiting faculty for this project. An honorarium is available to lecturers. Please contact Ronnie Davidson, EdD, for more information, 1/609/896-1717.

The diabetes roving symposia series ("Prevention of Diabetes-Related Lower Extremity Amputations"; "Nephropathy"; "Retinopathy"; and "Diabetes and Pregnancy") was expanded this year to include a fifth program, "Diabetes-Related Cardiovascular Disease." Norman Ertel, MD, serves as physician consultant for this project. He developed the curriculum and conducted the faculty development program for the lecturers. This series is available at no cost to requesting hospitals.

AMNJ has been actively involved in the nationwide Physician Initiated Continuing Medical Education (PICME) Project. As a member of this consortium of medical schools and societies, AMNJ can offer members a new and innovative means of gaining both AMA/PRA category I or II credit through individualized learning contracts. Physicians can define their own learning needs and those skills they wish to acquire. By using PICME's *Guidelines for Development of Independent Contracts,* AMNJ will coordinate and administer CME projects. ☐ Gerald Shapiro, MD

INFORMATIONAL BULLETIN

The accompanying list presents the official position of the Medical Society of New Jersey regarding bills currently in the Legislature. As bills of medical interest are introduced, they will be considered by the Society and supplemental bulletins will be supplied, indicating the Society's position.

The Society has adopted the following regular range of official positions concerning proposed legislation:

Active Support: All-out support for the measure.

Active Opposition: All-out opposition for the measure.

Support with Amendment: To indicate that the approval of the Society is subject to the revision of the specified unsatisfactory elements of the bill.

No Position: Considered, but not regarded as significant or relevant to the proper interest of the Society.

Senate Assembly (Active)

S-3409-Russo—Generic Drugs. Requires pharmacists to advise patients of the availability of generic drugs even though the physician prescribed "brand" necessary. **Active Opposition,** interferes with both the professional judgment of the pharmacist and of the physician.

S-3491-Lipman—Nurse Practitioners. Authorizes nurses to practice medicine and to prescribe medications other than scheduled drugs for inpatients. **Active Opposition,** nurses are not qualified to make a medical diagnosis or to prescribe therapeutic medications.

S-3510-Lipman—Physician Assistants. Provides registration for physician assistants through a separate licensing board. Does not require on-site supervision, but does call for a filed protocol. Maintains a supervising ratio of one physician to two physician assistants. It does not provide for participation in surgery except for suturing and wound care, incision, drainage of superficial infections, and cast application for simple fractures. **Active Opposition,** registration of physician assistants neither will contribute to the quality of medical care nor decrease the cost of medical care and will create confusion in the delivery system.

S-3539-Lesniak—Optometrists. Authorizes optometrists to prescribe drugs. **Active Opposition,** optometrists are not medical doctors and, therefore, should not be given the mandate, via legisla-

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New Address_____

City_____ State_____ Zip_____

tion, to prescribe and administer drugs. If the wrong medication is prescribed, what appears to be a simple problem could develop into a destructive process of the eye in a very short period of time. The bill is shortsighted in attempting to expand licensure by legislation rather than education and competence.

S-3588-Bassano—HIV Testing. The bill provides that a health care professional who is working in a hospital on the effective date of the bill and who may be exposed to another person's blood or body fluids in the course of performing that person's duties shall undergo the HIV test no later than the 120th day after the effective date of the bill, and periodically shall be retested, according to guidelines established by the Commissioner of Health; a health care professional who applies for employment at a hospital and who might be exposed to another person's blood or body fluids in the course of performing that person's duties shall be tested for HIV infection prior to commencing employment at the hospital, and periodically shall be retested, according to guidelines established by the Commissioner of Health; a health care professional who refuses to provide written informed consent to the HIV test shall be disqualified for employment at the hospital unless the person is exempted for good cause as determined by the commissioner; a person who is tested for HIV infection pursuant to this bill shall receive counseling before and after the testing in accordance with guidelines established by the commissioner; a hospital shall not administer an HIV test without first receiving the written informed consent of the subject of the test that is defined in the bill, or, if the subject of the test is legally incompetent, of an unauthorized representative of the test subject; a pregnant woman shall be routinely tested by her physician, as shall a newborn infant born in a nonhospital setting, for HIV infection, according to guidelines established by the commissioner; the New Jersey State Department of Health shall provide for a voluntary and confidential contact tracing system to identify and counsel persons who are at risk of HIV transmission as a result of contact with an HIV infected individual; and all test results are subject to the provisions regarding confidentiality and disclosure of medical records contained in P.L. 1989, c.303 (C.26:5C-5 et seq.). **Active Opposition,** unduly discriminates against health care workers, is not consistent with epidemiology and communicable disease protocols, and runs counter to scientific evidence.

S-3610-Bennett—Tuberculosis. Permits a board of education to test new students for tuberculosis if there is no record of a Mantoux test. **Active Support.**

A-3947-Bush—HIV. Amends state law to protect HIV-positive patients or patients with AIDS from discrimination. **Active Support.**

A-3948-Bush—HIV. Authorizes a physician to notify the sexual or needle-sharing partner of an HIV-positive patient and grants immunity when doing so in good faith. Requires written informed consent for HIV testing and directs the New Jersey State Department of Health to distribute guidelines on universal precautions. Authorizes minors to consent to testing for HIV and repeals current law that requires notification that a decedent had HIV, hepatitis B, or any other contagious disease. **Active Support.**

A-3949-Bush—HIV/Anatomical Gifts. Requires living organ donors to consent in writing to HIV tissue testing. **Active Support.**

A-4657-Roma—Joint and Several Liability. Eliminates joint and several liability except when defendants acted in concert. Allows attorneys' fees to successful litigants. **Active Support.**

A-4779-Rocco—Tanning Facilities. Requires tanning facilities to supply written warnings and also precludes minors from using tanning facilities. **Active Support.**

A-4822-Kalik—State Board of Medical Examiners (SBME). Provides that at least two of the ten physician members of SBME be osteopathic physicians. **Active Support.**

A-4902-Pascrell—Acupuncture. Authorizes noncertified acupuncturists to practice in approved drug and alcohol treatment programs. **Active Opposition,** discriminates against patients with diseases of addiction and exposes them to treatment by unlicensed personnel.

A-4904-De Croce—Organ Donation. Requires that the state driver's manual contain information on organ donation. **Active Support.**

A-4912-Impreveduto—Licensure/Burden of Proof. Raises the standard of proof in medical and podiatry disciplinary proceedings to "clear and convincing." **Active Support.**

A-4933-Vandervalk—Medical Malpractice/Damages. Places a $250,000 cap on noneconomic damages in medical malpractice cases. **Active Support.**

A-4934-Vandervalk—Medical Malpractice/Arbitration. Provides that arbitration shall be used when the amount in controversy is less than $50,000. **Active Support.**

A-5054-Doyle—Physician Courtesy Referral. Establishes a voluntary physician courtesy referral program for Medicare patients eligible for PAAD. **Active Support.**

A-5092-Mecca—Patient Confidentiality. Provides a civil penalty for publishing a patient's name without written permission. **Active Support.**

Senate/Assembly (Monitor)

S-3090-Cafiero—Emergency Services. Provides that hospitals with an accredited emergency medical service may apply to the New Jersey State Department of

Health to develop and maintain an intermediate life-support program with local squads under regulations adopted by the Commissioner. **Support with Amendment** pending the following: Section 3.b. be revised to indicate in the event that direct voice communications fail, emergency medical technicians–intermediate (EMTI) should be restricted to a limited set of interventions as developed by the Mobile Intensive Care Unit (MICU) Medical Directors Committee and approved by the Commissioner of Health. Section 10 be revised to indicate that the State MICU Medical Directors Committee, which currently decides on therapeutic and pharmacological interventions for MICU paramedics, develops protocols to be approved by the Commissioner of Health. Inclusion of mandatory continuing education and periodic recertification requirements for EMTIs.

S-3140-Zane—Assault Weapons. Amends the current ban on assault weapons. **No Position.**

S-3383-Van Wagner—Smoking. Requires health insurers to provide benefits for successful completion of approved smoking cessation programs. **No Position.**

S-3642-Lesniak—Irradiated Food. Prohibits the distribution and sale of irradiated food. **Action Deferred,** pending further information from the Council on Public Health.

S-3655-Codey—Medicaid. Extends Medicaid eligibility to certain children up to age 19. **No Position.**

A-3959-Felice—Organ Donations. Prohibits the sale or purchase of organs. **No Position.**

A-4001-Martin—State Psychiatric Study Commission. Creates a 13-member study commission on the long-term role of the state psychiatric hospitals and developmental centers. **Action Deferred,** pending further information from the Council on Mental Health.

A-4692-Catania—Elderly Abuse. Requires every person who has reasonable cause to believe an elderly or disabled person is the victim of abuse or exploitation to report that information to the Commissioner of Human Services or his designee. **No Position.**

A-4802-Farragher—Lyme Disease. Establishes a prevention and control program within the New Jersey State Department of Health. **No Position.**

A-4918-Duch—HIV/Physicians and Dentists. Requires HIV-positive physicians and dentists to obtain written consent from their patients before performing invasive procedures. **Action Deferred,** pending information from Task Force on AIDS.

A-4955-Kelly—Irradiated Foods. This bill eliminates the expiration date on a statute banning the sale of irradiated food. **Action Deferred,** pending further information from the Council on Public Health.

A-5071-Impreveduto—Radiology Technology. Amends existing law to change "certification" to "licensure," establishes a special category of diagnostic mammographic radiologic technician, eliminates special categories for orthopedic and urologic technicians, and converts to an annual licensing cycle. Continuing education will be required as determined by regulation. **Action Deferred,** pending further information from the Radiological Society of New Jersey and the Committee on Cancer Control.

A-5078-Gill—Medicaid. Expands Medicaid coverage to children between 6 and 19 years of age whose family income does not exceed 100 percent of the federal poverty level. **No Position.**

A-5099-Baker—Electromagnetic Fields. Requires the Radiation Protection Commission to adopt standards for electromagnetic fields. **Action Deferred,** pending further information from the Council on Public Health and the Radiological Society of New Jersey. □

PLACEMENT FILE

The following physicians have written to the executive offices of MSNJ seeking information on opportunities for practice in New Jersey. If you are interested in information concerning these physicians, we suggest you make inquiries directly to them.

Cardiology

Alan E. Kravitz, MD, 26900 Cedar Rd., #304, Beachwood, OH 44122. Jefferson 1969. Also, internal medicine. Board certified. Also, board certified (IM). Group or partnership. Available.

Internal Medicine

Thomas F. De Blasio, MD, 100 Franklin St., Apt. 8B8, Morristown, NJ 07960. St. George's 1985. Board eligible. Solo or partnership. Available July 1992.

Sheryl S. Hertel, MD, 6205 Brogan Pl., St. Louis, MO 63128. St. Louis 1986. Also, pediatrics, Board certified. Board eligible (PED). Group. Available.

Alan E. Kravitz, MD, 26900 Cedar Rd., #304, Beachwood, OH 44122. Jefferson 1969. Also, cardiology. Board certified. Also, board certified (CARD). Group or partnership. Available.

Cynthia K. Menack, MD, 3132 Perry Ave., Apt. 2A, Bronx, NY 10467. Mount Sinai 1989. Board eligible. Group practice or medical clinic. Available July 1992.

Pathology

Sarita Khanijo, MD, 1710 N.W. Calkins, Roseburg, OR 97470. MGM Medical College (India) 1976. Board certified. Group or partnership. Available.

Pulmonary Medicine

Vinod Khanijo, MD, 1710 NW Calkins, Roseburg, OR 97470. Delhi University (India) 1963. Also, critical care. Board certified. Solo. Available July 1992.

Surgery

Victoria Lee, MD, 459 South St., #204, Fitchburg, MA 01420. Howard 1981. Board certified. Group, HMO, partnership. Available. □

THE NEWLY APPROVED MEDICAL ASSOCIATION TRUSTS
(Summit Bancorporation, Trustee)
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* V.E.B.A. PLAN

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CONTINUING EDUCATION

ANESTHESIOLOGY

March

4 **Nonoperative Management of Chronic Back Pain**
10:30-11:30 A.M.—St. Mary's Hospital, Passaic
(AMNJ)

20-22 **33rd Annual NJ Postgraduate Anesthesia Seminar**
Hyatt Cherry Hill, Cherry Hill
(AMNJ)

DERMATOLOGY

February

5
12
19
26 **Dermatology Grand Rounds**
6-9 P.M.—Rutgers Community Health Plan, New Brunswick
(UMDNJ)

11 **Monthly Meeting**
7 P.M.—Schering Corporation, Kenilworth
(Dermatological Society of New Jersey and AMNJ)

19 **Dermatological Conference**
6-9 P.M.—Rutgers Community Health Plan, U.S. Highway #1, New Brunswick
(UMDNJ)

March

4
11
18
25 **Dermatology Grand Rounds**
6-9 P.M.—Rutgers Community Health Plan, New Brunswick
(UMDNJ)

10 **Monthly Meeting**
7 P.M.—Schering Corporation, Kenilworth
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6-9 P.M.—Rutgers Community Health Plan, U.S. Highway #1, New Brunswick
(UMDNJ)

INFECTIOUS DISEASE

February

4 **Infectious Control in the HIV Era**
1-2 P.M.—Mediplex Rehab., Camden
(AMNJ)

7 **AIDS and Ethics**
9 A.M.-4 P.M.—JFK Conference Center, Edison
(AAMFT)

7
14
21
28 **Inter-Jersey Infectious Disease Rounds**
Hackensack Medical Center, Newark Beth Israel Medical Center, St. Joseph's Hospital and Medical Center, Overlook Hospital, and University Hospital
(UMDNJ and AMNJ)

12 **Identification and Management of Asymptomatic HIV Infection**
1-2 P.M.—VA Medical Center, Lyons
(AMNJ and NJDOH)

19 **AIDS: Ethical Issues**
8:30-9:30 A.M.—West Jersey Hospital System, Voorhees
(AMNJ and NJDOH)

26 **Diagnosis and Treatment of AIDS**
2:30-3:30 P.M.—Trenton Psychiatric Hospital, Trenton
(AMNJ and NJDOH)

March

4 **Identification and Management of Asymptomatic HIV Infection**
11:30 A.M-12:30 P.M.—Rahway Hospital, Rahway
(AMNJ and NJDOH)

4 **Psychiatric Aspects of AIDS**
2:30-3:30 P.M.—Ancora Psychiatric Hospital, Hammonton
(AMNJ)

6
13
20
27 **Inter-Jersey Infectious Disease Rounds**
Hackensack Medical Center, Newark Beth Israel Medical Center, St. Joseph's Hospital & Med. Ctr., Univ. Hosp., and Overlook Hospital
(UMDNJ and AMNJ)

6 **AIDS Training and Resource Program for Hospital Health Educators**
12 Noon-1 P.M.—South Jersey Hospital System, Bridgeton
(AMNJ and NJDOH)

11 **AIDS Training and Resource Program for Hospital Health Educators**
9-10 A.M.—Elizabeth General Medical Center, Elizabeth
(AMNJ and NJDOH)

11 **Infectious Control in the HIV Era**
9-10 A.M.—Elizabeth General Medical Center, Elizabeth
(AMNJ)

11 **Infectious Control in the HIV Era**
11:30 A.M.-12:30 A.M.—Hamilton Hospital, Hamilton
(AMNJ)

25 **Diagnosis and Treatment of AIDS**
10-11 A.M.—Hunterdon Developmental Center, Clinton
(AMNJ and NJDOH)

MEDICINE

February

4 **Family/School Relationships**
8:30-10 A.M.—Elizabeth General Medical Center, Elizabeth
(EGMC)

4 **Prevention of Lower Extremity Amputations**
12 Noon-1 P.M.—St. Mary's Hospital, Hoboken
(AMNJ)

4 **Risk Communication**
12:15-1:30 P.M.—Health and Agriculture Building, Trenton
(AMNJ)

5
12
19
26 **Medical Lecture Series**
10:30 A.M.-12 Noon—Christ Hospital, Jersey City
(Christ Hospital)

5 **Endocrinology Monthly Meeting**

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6-9 P.M.—Holiday Inn, Newark Airport, Newark
(AMNJ)

5 **Current Chemotherapy**
10:30-11:30 A.M.—St. Mary's Hospital, Passaic
(St. Mary's Hospital)

5 **Endocrinology Grand Rounds**
12 11:30 A.M.-1 P.M.—VA Medical
19 Center, East Orange
26 *(AMNJ)*

5 **Interhospital Endocrine**
12 **Rounds**
19 3:30-5:30 P.M.—Newark Beth
26 Israel Medical Center, University Hospital, VA Medical Center, and United Hospitals Medical Center
(AMNJ)

5 **Intensive Review of Internal**
12 **Medicine**
19 5-7 P.M.—University Hospital,
26 Medical Education Bldg., New Brunswick
(UMDNJ and AMNJ)

5 **Diabetic Nephropathy**
11:30 A.M.-12:30 P.M.—Rahway Hospital, Rahway
(AMNJ and NJDOH)

6 **Winter Meeting: NJ Gastroenterological Society**
6:30 P.M.—Short Hills Hilton, Short Hills
(AMNJ)

6 **Diabetes in Pregnancy**
1:30-2:30 P.M.—Essex County Hospital Center, Cedar Grove
(AMNJ)

6 **New Treatments in Cardiovascular Disease**
2:30-3:30 P.M.—Greystone Park Psychiatric Hospital, Greystone Park
(AMNJ)

6 **Urology Grand Rounds**
13 7-9 P.M.—Robert Wood
20 Johnson Medical School,
27 New Brunswick
(UMDNJ)

7 **Health Promotion Throughout the Life Span**
12 Noon-1 P.M.—Monmouth Medical Center, Long Branch
(Monmouth Medical Center)

7 **Camouflaged Medical Illness**
12 Noon-1 P.M.—South Jersey Hospital System, Bridgeton
(AMNJ)

10 **Esophageal and Swallowing Syndrome**
7-8 P.M.—Wallkill Valley Hospital, Sussex
(AMNJ)

11 **Diabetic Nephropathy**
11 A.M.-12 Noon—West Jersey Health System, Voorhees
(AMNJ and NJDOH)

11 **Health Promotion Throughout the Life Span**
12 Noon-1 P.M.—The Mountainside Hospital, Montclair
(The Mountainside Hospital)

11 **Psychoanalytic Perspectives on the Management of Acting Out Adolescents**
8:30-10 A.M.—Elizabeth General Medical Center, Elizabeth
(EGMC)

12 **Fluid and Electrolyte Imbalance**
10:30-11:30 A.M.—St. Mary's Hospital, Passaic
(AMNJ)

12 **Diabetic-Related Cardiovascular Disease**
9-10 A.M.—Elizabeth General Medical Center, Elizabeth
(AMNJ and NJDOH)

12 **Diabetic Retinopathy**
12 Noon-1 P.M.—Memorial Hospital of Salem County, Salem
(AMNJ and NJDOH)

12 **Glaucoma Update**
10:30-11:30 A.M.—St. Mary's Hospital, Passaic
(St. Mary's Hospital)

13 **SIDS in New Jersey and MCADD**
8:30-9:30 A.M.—St. Peter's Medical Center, New Brunswick
(MCADD)

17 **Medical Problems in the Elderly**
12 Noon-1 P.M.—Memorial Hospital of Burlington County, Mount Holly
(Memorial Hospital of Burlington County)

19 **Prevention of Lower Extremity Amputations**
10-11 A.M.—Hunterdon Developmental Center, Clinton
(AMNJ and NJDOH)

19 **Diabetes in Pregnancy**
10:30-11:30 A.M.—St. Mary's Hospital, Passaic
(AMNJ and NJDOH)

19 **Health Promotion Throughout the Life Span**
9-10 A.M.—Warren Hospital, Phillipsburg
(Warren Hospital)

19 **Managing Stress Effectively**
2:30-3:30 P.M.—Ancora Psychiatric Hospital, Hammonton
(Hammonton)

20 **Medical Problems in the Elderly**
12 Noon-1 P.M.—St. Mary's Hospital, Passaic
(St. Mary's Hospital)

20- **Lower Extremity Prosthetics**
23 **and Orthotics**
8-5 P.M.—Kessler Institute, West Orange
(Kessler Institute)

20 **Hypertensive Strategies for the 1990s**
5-6:30 P.M.—Somerset Medical Center, Somerville
(Somerset Medical Center)

21 **Medical Problems of the Elderly**
11:30 A.M.-12:30 P.M.—Greenville Hospital, Jersey City
(AMNJ)

24 **Functional Assessment of the Elderly**
1-2 P.M.—New Lisbon Developmental Center, New Lisbon
(AMNJ)

26 **Living Wills**
10:30-11:30 A.M.—Christ Hospital, Jersey City
(AMNJ)

March

3 **Medical Problems of the Elderly**
11:30 A.M.-12:30 P.M.—Muhlenberg Regional Medical Center, Plainfield
(AMNJ)

3 **Diabetic Nephropathy**
12 Noon-1 P.M.—St. Mary's Hospital, Hoboken
(AMNJ)

4 **Medical Lecture Series**
11 10:30 A.M.-12 Noon—Christ
18 Hospital, Jersey City
25 *(Christ Hospital)*

4 **Endocrinology Monthly Meeting**
6-9 P.M.—Holiday Inn, Newark Airport, Newark
(AMNJ)

4 **Endocrinology Grand Rounds**
11 11:30 A.M.-1 P.M.—VA Medical
18 Center, East Orange
25 *(AMNJ)*

4 **Interhospital Endocrine**
11 **Rounds**
18 3:30-5:30 P.M.—Newark Beth

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January-March 1992

JANUARY 1992

January 8, 1992
THE USE OF CATHETER ABLATION FOR TREATMENT OF PATIENTS WITH SVT
Melvin M. Scheiman, M.D.
Professor of Medicine
University of California
Division of Cardiology
Moffett/Long Hospital
San Francisco, CA

January 15, 1992
INFLAMMATORY BOWEL DISEASE
Harris R. Clearfield, M.D.
Professor of Medicine
Director, Division of Gastroenterology
Hahnemann University

January 22, 1992
CONVERSIONS FROM CHRONIC TO ACUTE CORONARY SYNDROMES
James T. Willerson, M.D.
Professor and Chairman
Department of Internal Medicine
University of Texas Medical School
Houston, TX

CONVENTIONAL ANTITHROMBOTIC THERAPY (ASPIRIN & WARFARIN) IN PRIMARY & SECONDARY PREVENTION OF CORONARY ARTERY DISEASE
James H. Chesebro, M.D.
Professor of Medicine
Mayo Medical School
Consultant in Cardiovascular Diseases
Mayo Clinic
Rochester, MN

January 29, 1992
MOHS SURGERY IN THE TREATMENT OF SKIN CANCER
Nathan R. Howe, M.D., Ph.D.
Assistant Professor of Medicine (Dermatology)
Chief, Section of Dermatologic Surgery
Division of Dermatology
Hahnemann University

FEBRUARY 1992

February 5, 1992
PREVENTION OF RENAL FAILURE IN THE GERIATRIC PATIENT
Michael F. Michalis, M.D.
Professor of Clinical Medicine
New York Medical College
Director, Division of Nephrology
Lenox Hill Hospital

February 12, 1992
GENITAL HERPES
Lawrence Corey, M.D.
Professor of Laboratory Medicine, Microbiology and Medicine
Head, Virology Division
University of Washington
Seattle, WA

February 19, 1992
CUTANEOUS MANIFESTATIONS OF SYSTEMIC DISEASE
Cherie M. Ditre, M.D.
Assistant Professor of Medicine
Division of Dermatology
Hahnemann University

February 26, 1992
CARDIOVASCULAR DISORDERS AND ATHEROSCLEROSIS IN POST-MENOPAUSAL WOMEN
Jay Michael Sullivan, M.D.
Professor of Medicine
Chief, Division of Cardiovascular Diseases
University of Tennessee College of Medicine
Memphis, TN

MARCH 1992

March 4, 1992
CLINICAL PATHOLOGICAL CONFERENCE: VIOLANCEOUS MACULAR RASH, HEPATOMEGALY, FEVER & NEUROLOGIC ABNORMALITIES
Edward Dimitry, M.D.
Chief Resident, Department of Medicine
Hahnemann University
Cathy Jensen, M.D.
Chief Resident, Department of Medicine
Hahnemann University
Richard Maniglia, M.D.
Chief Resident, Department of Medicine
Hahnemann University
Jay Patel, M.D.
Chief Resident, Department of Medicine
Hahnemann University

March 11, 1992
CARDIOLOGY—ISSUES AND ANSWERS FOR THE 90's
Sylvan L. Weinberg, M.D.
Clinical Professor of Medicine
Wright State University
Dayton, OH

March 18, 1992
OCULAR MANIFESTATIONS OF AUTOIMMUNE DISEASE
Stephen Sinclair, M.D.
Professor of Ophthalmology
Vice Chairman, Department of Ophthalmology
Hahnemann University

March 25, 1992
HYPERTENSIVE NEPHROSCLEROSIS: IS IT BENIGN?
Jerome Porush, M.D.
Professor of Medicine
SUNY Health Science Center
Chief, Nephrology and Hypertension
Brookdale Hospital and Medical Center
Brooklyn, NY

Hahnemann University Department of Medicine
Wednesday Medical Seminar Series
8:30 a.m.-3:30 p.m.

January 21-22, 1992
ANTITHROMBOTIC THERAPY IN CORONARY ARTERY DISEASE

February 11, 1992
DIAGNOSIS AND TREATMENT OF SEXUALLY TRANSMITTED DISEASES

March 24-25, 1992
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25 Israel Medical Center, University Hospital, VA Medical Center, and United Hospitals Medical Center *(AMNJ)*

4 **Intensive Review of Internal**
11 **Medicine**
18 4-7 P.M.—University Hospital,
25 Medical Education Bldg., New Brunswick *(UMDNJ and AMNJ)*

4 **Diabetic Retinopathy** 10:30-11:30 A.M.—Christ Hospital, Jersey City *(AMNJ)*

5 **Health Promotion Throughout the Life Span, for People with Down's Syndrome** 8-9 P.M.—Overlook Hospital, Summit *(AMNJ)*

5 **Urology Grand Rounds**
12 7-9 P.M.—Robert Wood
19 Johnson Medical School,
26 New Brunswick *(UMDNJ)*

6 **Diabetes-Related Cardiovascular Disease** 10:30-11:30 A.M.—Chilton Memorial Hospital, Pompton Plains *(AMNJ)*

9 **Annual Review Course in Physical Medicine** 8 A.M.-5 P.M.—Kessler Institute, West Orange *(Kessler Institute)*

9 **Proper Use of Endoscopy** 11:30 A.M.-1 P.M.—East Orange General Hospital, East Orange *(AMNJ)*

10 **Rape Trauma Syndrome** 8:30-11 A.M.—Elizabeth General Medical Center, Elizabeth *(EGMC)*

10- **Advance Directives**
11 5:30-10 P.M.—Sheraton Meadowlands Hotel, East Rutherford *(AMNJ)*

11 **Hearing Loss: Prevention or Treatment** 10:30-11:30 A.M.—St. Mary's Hospital, Passaic

11 **New CDC Lead Guidelines** 12:15-1:30 P.M.—Health and Agriculture Building, Trenton *(AMNJ)*

11 **Diabetes-Related Cardiovascular Disease** 1-2 P.M.—Veterans Administration Medical Center, Lyons *(AMNJ)*

11 **Diabetic Nephropathy** 1:30-2:30 P.M.—Essex County Hospital Center, Cedar Grove *(AMNJ and NJDOH)*

11 **14th Annual Meeting** 1:30-4:30 P.M.—Englewood Hospital, Englewood *(Vascular Society of New Jersey)*

13 **Medical Problems of the Elderly** 10-11 A.M.—Runnells Specialized Hospital, Berkeley Heights *(AMNJ)*

13 **Medical Problems of the Elderly** 12 Noon-1 P.M.—South Jersey Hospital System, Bridgeton *(AMNJ)*

14 **Resident Presentations** 9 A.M.—Kessler Institute, West Orange *(Kessler Institute)*

14- **Diagnosis and Management of**
15 **Musculoskeletal Disorders: State of the Art 1992** 8 A.M.-5 P.M.—Kessler Institute, West Orange *(Kessler Institute)*

16 **Diabetes-Related Cardiovascular Disease** 1-2 P.M.—New Lisbon Developmental Center, New Lisbon *(AMNJ)*

17 **Diabetes-Related Cardiovascular Disease** 11:30 A.M.-12:30 P.M.—Hamilton Hospital, Trenton *(AMNJ)*

17 **Insights into Protein Wasting in Uremia** 7:30-9:30 P.M.—Overlook Hospital, Summit *(AMNJ)*

17 **Perspectives on SIDS** All day—Sheraton Garden, Freehold *(NJ SIDS Resources)*

18 **Diabetes-Related Cardiovascular Disease** 2:30-3:30 P.M.—Ancora Psychiatric Hospital, Hammonton *(AMNJ)*

18 **Camouflaged Medical Illness** 8:30-9:30 A.M.—West Jersey Health System, Voorhees *(AMNJ)*

18 **Hematology and Ferrokinetics** 10:30-11:30 A.M.—St. Mary's Hospital, Passaic *(AMNJ)*

18 **Health Promotion Throughout the Life Span, for People with Down's Syndrome** 8-9 A.M.—St. Joseph's Hospital and Medical Center, Paterson *(AMNJ)*

18 **Prevention of Lower Extremity Amputations** 1:30-2:30 P.M.—Central New Jersey Medical Group, Somerset *(AMNJ and NJDOH)*

18 **Diabetes-Related Cardiovascular Disease** 2:30-3:30 P.M.—Ancora Psychiatric Hospital, Hammonton *(AMNJ)*

19 **Medical Problems in the Elderly** 11:30 A.M.-12:30 P.M.—Jersey City Medical Center, Jersey City *(AMNJ)*

19 **Highly Resistant Borderline Narcissistic Cases** 1:30-2:30 P.M.—Essex County Hospital Center, Cedar Grove *(AMNJ)*

24 **Practical Aspects of Diabetes**

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Angina Pectoris: Diagnosis and Management

Moderator: William J. Untereker, M.D.

3:00-3:30	Outpatient cardiac catheterization: Is it safe, feasible, and for whom?—***William J. Untereker, M.D.***
3:30-4:00	Recognition and management of patients with angina pectoris: Who needs catheterization?—***J. David Ogilby, M.D.***
4:00-5:00	Case Presentations—***Scott Fuchs, M.D.*** Panel Discussion—***William Corin, M.D., Ancil A. Jones, M.D., Robert I. Katz, M.D.***

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12:15-1:30 P.M.—Health and Agriculture Building, Trenton
(AMNJ)

24 **Patient Care Monitoring**
1:30-2:30 P.M.—Trenton Psychiatric Hospital, Trenton
(AMNJ)

25 **Medical Problems of the Elderly**
10:30-11:30 A.M.—St. Mary's Hospital, Passaic
(AMNJ)

25 **Diabetes-Related Cardiovascular Disease**
2:30-3:30 P.M.—Trenton Psychiatric Hospital, Trenton
(AMNJ)

25 **Chronic Pain Management and Issues Related to Iatrogenic Addiction**
10:30-11:30 A.M.—Christ Hospital, Jersey City
(AMNJ)

25-29 **Annual Meeting and Scientific Assembly**
Caesars, Atlantic City
(NJ Academy of Family Physicians and AMNJ)

ONCOLOGY & RADIATION ONCOLOGY

February

5 **Current Chemotherapy**
10:30-11:30 A.M.—St. Mary's Hospital, Passaic
(AMNJ)

6 **Tumor Board Conference**
13 12:15-1:15 P.M.—Mercer
20 Medical Center, Trenton
27 *(Mercer Medical Center)*

20 **Cocktail Reception**
6:30-9 P.M.—Hyatt Regency, New Brunswick
(Head and Neck Oncology Section, AMNJ)

March

4 **Annual Clinical Abstract Meeting**
1:30-5 P.M.—The Manor, West Orange
(Oncology Society of New Jersey)

5 **Tumor Board Conference**
12 12:15-1:15 P.M.—Mercer
19 Medical Center, Trenton
26 *(Mercer Medical Center)*

25 **Cocktail Reception**
6:30-9 P.M.—The Manor, West Orange
(Radiation Oncology Section, AMNJ)

PSYCHIATRY

February

18 **Art Therapy**
8:30-10 A.M.—Elizabeth General Medical Center, Elizabeth
(EGMC)

19 **Managing Stress Effectively**
2:30-3:30 P.M.—Ancora Psychiatric Hospital, Hammonton
(AMNJ)

20 **Psychiatric Emergencies**
1:30-2:30 P.M.—Essex County Hospital Center, Cedar Grove
(AMNJ)

25 **Patient Care Monitoring**
1:30-2:30 P.M.—Trenton Psychiatric Hospital, Trenton
(AMNJ)

25 **New Advanced Cognitive Therapy**
8:30-10 A.M.—Elizabeth General Medical Center, Elizabeth
(EGMC)

March

4 **Psychiatric Aspects of AIDS**
2:30-3:30 P.M.—Ancora Psychiatric Hospital, Hammonton
(AMNJ)

4 **Psychopharmacology of Depression in Children**
8:30-10 A.M.—Elizabeth General Medical Center–West, Elizabeth
(EGMC)

RADIOLOGY

February

20 **Radiology Lecture**
1:30-5 P.M.—Saint Barnabas Medical Center, Livingston
(Saint Barnabas Medical Center)

20 **MRI Conference and Case Presentation**
7:30-9:30 P.M.—Saint Barnabas Medical Center, Livingston
(Radiological Society of New Jersey and Diagnostic Radiology Section, AMNJ)

March

16 **Radiology Lecture**
1:30-5 P.M.—Saint Barnabas Medical Center, Livingston
(Saint Barnabas Med. Ctr.)

19 **MRI Conference and Case Presentation**
7:30-9:30 P.M.—Saint Barnabas Medical Center, Livingston
(Radiological Society of NJ and AMNJ)



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IN MEMORIAM

JOHN T. CHABORA

At the untimely age of 46, John Thomas Chabora, MD, died on August 16, 1991. Dr. Chabora was born in Passaic on July 3, 1945. Dr. Chabora was awarded a medical degree from the University of Medicine and Dentistry of New Jersey, Newark, in 1973. He completed an internship at Albert Einstein College of Medicine Hospital, New York, in 1974 and residencies at Bellevue Medical Center, New York, in 1976 and at Cornell Medical Center, New York, in 1980. In 1975, Dr. Chabora received his New Jersey and New York medical licenses. Specializing in obstetrics and gynecology, Dr. Chabora practiced in Long Branch and Shrewsbury. He was assistant attending at Monmouth Medical Center, Long Branch. Dr. Chabora was a member of our Monmouth County component and of the American Medical Association. Dr. Chabora resided in West Long Branch.

JAMES J. LUCEY

Lifetime Perth Amboy resident James Joseph Lucey, MD, died on September 17, 1991, at the age of 78. Dr. Lucey was born on December 28, 1912, in Perth Amboy. He earned a medical degree from Temple University School of Medicine, Philadelphia, in 1937. Two years later, Dr. Lucey received his New Jersey medical license. Dr. Lucey completed an internship at Temple University Hospital, Philadelphia. He specialized in obstetrics and gynecology and practiced in Perth Amboy for over 50 years. Dr. Lucey was past-president of the medical staff at Raritan Bay Medical Center, Perth Amboy, and was a member of the board of directors at Raritan Bay Health Services Corporation. During World War II, Dr. Lucey was a lieutenant commander in the United States Navy, serving in the European and Pacific theaters. He was awarded 11 Battle Stars and the Temple University Medical School Medal of Honor for the most combat service of any medical alumnus. Dr. Lucey was a member of our Middlesex County component, of the American Medical Association, and of the New Jersey Obstetric and Gynecologic Society. Dr. Lucey was a fellow of the American College of Obstetricians and Gynecologists.

EDWARD W. LUKA

At the untimely age of 58, Edward Walter Luka, MD, of Garfield, died on August 25, 1991. Dr. Luka was born in Nisko, Poland, on May 21, 1933, and relocated as a young child with his family to Garfield. He was awarded a medical degree from Boston University School of Medicine, Massachusetts, in 1958. In 1959, Dr. Luka received his New Jersey medical license. Dr. Luka completed an internship in 1959 at Hackensack Hospital. After serving for two years in the United States Army as a captain, Dr. Luka completed a residency at New York University Medical Center, New York, in 1964. Specializing in dermatology, Dr. Luka practiced in Garfield. He served as an instructor at New York University School of Medicine, New York; director at St. Mary's Hospital, Passaic, and at The General Hospital Center at

Passaic; and attending at Beth Israel Hospital, Passaic. Dr. Luka was a diplomate of the American Board of Dermatology, and a member of our Bergen and Passaic County components and of the American Medical Association. Dr. Luka was a trustee of St. Mary's Hospital, Passaic, and of the Medical Society of New Jersey's political action committee, JEMPAC. In 1982, he was appointed by Governor Thomas Kean to the State Board of Medical Examiners.

VLADIMIR ONUFERKO

A member of our Hudson County component, Vladimir Onuferko, MD, of Jersey City, passed away on September 6, 1991, at the grand age of 82. Dr. Onuferko was born in the Ukraine on July 15, 1909. Dr. Onuferko was awarded a medical degree from Krakow Medical School, Poland, in 1937. He received his New Jersey medical license in 1955. Dr. Onuferko was an anesthesiologist with a practice in Jersey City; he was affiliated with Christ Hospital, the former Margaret Hague Maternity Hospital, and the former Fairmont Hospital, all in Jersey City. Dr. Onuferko served in the Polish Army.

RICHARD W. RADO

On May 18, 1927, Richard William Rado, MD, was born in Newark. He died on August 30, 1991, at the age of 64. Dr. Rado was awarded a medical degree from the University of Berne, Switzerland, in 1954. In 1956, Dr. Rado received his license to practice medicine in New Jersey. He completed an internship and a residency at Martland Medical Center, Newark, in 1956 and 1959, respectively. A general surgeon, Dr. Rado practiced in Butler. He was affiliated for many years with Chilton Memorial Hospital, Pompton Plains, serving as chairman of the emergency department from 1964 to 1975, president of the medical staff in 1975, and chief of surgery from 1980 to 1983. Dr. Rado was a United States Navy veteran of World War II. Dr. Rado was a fellow of the American College of Surgeons, and a member of our Passaic and Essex County components and of the Academy of Medicine of New Jersey. Dr. Rado resided in Pompton Plains, Kinnelon, and Oak Ridge.

VINCENT M. WHELAN

Rumson resident Vincent Matthew Whelan, MD, passed away on June 7, 1991, at the grand age of 80. Dr. Whelan was born in Grantwood on September 6, 1910. He was awarded a medical degree from Harvard Medical School, Boston, in 1936. After serving in the United States military during World War II, Dr. Whelan received his license to practice medicine in New Jersey in 1946. A radiologist, Dr. Whelan practiced in Red Bank and was affiliated with Riverview Hospital, Red Bank; Monmouth Medical Center; and the former Fitkin Memorial Hospital, Neptune. Dr. Whelan was a diplomate of the American Board of Radiology and of the American Board of Nuclear Medicine, and a member of our Monmouth County component and of the American Medical Association.

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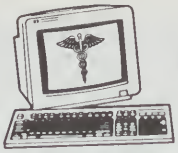
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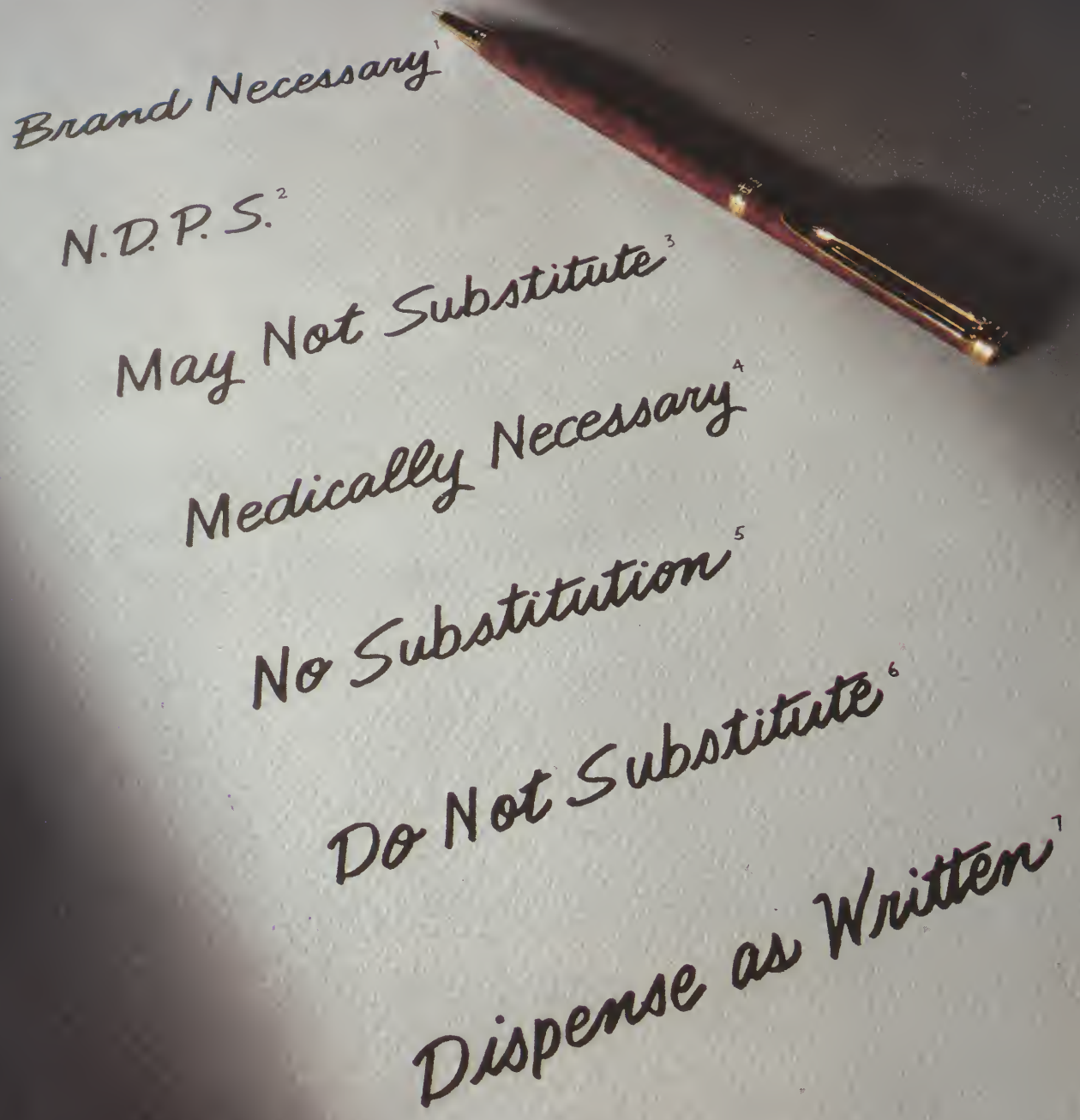
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Newswatch

LAME DUCK LEGISLATURE FINALLY LEAVES TOWN...

Mandatory Medicare assignment did not pass. Physician assistants won the right to work in New Jersey. Nurse practitioners gained expanded powers if they work under the direction of a physician. Optometrists won the authority to prescribe medications without the benefit of a medical education--but they sacrificed "tons of bucks" and, perhaps, their ethical anchor, in moving their bill through the Legislature.

These are some of the activities of the lame duck Legislature. The lame ducks met the entire week of January 6. For the entire week and again on January 13, the final day, the mandatory Medicare assignment bill was hovering in the Assembly.

MANDATORY MEDICARE ASSIGNMENT...

We had waged a year-long battle against the bill to overcome Governor Florio's frequent calls for its passage. The bill, released by the Assembly Senior Citizens Committee last February, would have prohibited physicians from charging more than the Medicare "reasonable" rates when treating a senior whose annual income is less than $34,125 if single or $41,875 if married.

The bill then hovered in the Appropriations Committee for ten months, the drama culminating in a lengthy hearing in December, attended by more than 50 physicians, most of whom testified. Following that hearing, all eight Democrats on the Committee agreed to roll back the income eligibility criteria to match that of the Pharmaceutical Assistance to the Aged and Disabled (PAAD) program; $15,700 for singles and $19,250 for couples. About 250,000 seniors are enrolled in PAAD. In contrast, the bill originally would have covered more than 730,000 Medicare beneficiaries.

At 8 p.m. on January 13, the Assembly adjourned without calling the bill to a vote. But even if it had passed in the lower house, we saw its prospects in the Senate as minimal.

While the Florio administration took its lumps on Medicare assignment, it was pleased with the passage of two elements of its plan to "contain" the rising cost of health care: the licensure of physician assistants and nurse practitioners.

NURSES AND PHYSICIAN ASSISTANTS...

In particular, the passage of the physician assistants (PA) bill was a victory for the University of Medicine and

Governor Florio did not sign the bill by January 21 and it died. In his veto memo, the governor said the bill would make it "significantly more difficult for the state to discipline physicians and podiatrists," and explained, "I cannot affix my signature to this legislation. The state has a paramount interest in the regulation of professions that protect life and health. I believe that the public health must be protected by maintaining the current standard of proof. To raise the standard for these professions would be inconsistent with the standards for other professional boards regulated by the Department of Law and Public Safety, Division of Consumer Affairs. It would be a serious blow to our efforts to protect the health, safety, and welfare of the people of New Jersey."

If you are wondering how this concern for health, safety, and welfare can be consistent with the governor's signing a law that allows optometrists to use and prescribe beta-blockers, you probably are not alone. *Clark W. Martin

February 1992

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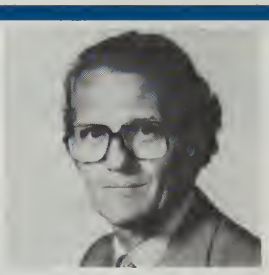
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Gerhard Hansen, the discoverer of *Mycobacterium leprae,* is the subject of the 1991 prizewinning paper of the Medical History Society of New Jersey.
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MSNJ NEWSLETTER

DEPE DEVELOPING NEW INCINERATOR RULES

In an effort to streamline regulation, the New Jersey State Department of Environmental Protection and Energy (DEPE) intends to limit hearings, to speed up reviews, and to centralize regulatory authority for hospital incineration and waste management. A proposed regulation on this subject may appear in the spring.

To DEPE experts, incineration is less desirable than source reduction, recycling, or treatment, and indeed is the waste management approach "of last resort." Hospitals that do use incinerators should regionalize their operations, in the view of DEPE experts. DEPE has supported Burlington Memorial Hospital in its pioneer effort to replace incineration with a new—and controversial—microwave technology, which also is being explored by UMDNJ and CentraState, JFK-Edison, and Cooper Hospitals, while about 20 hospitals have applied for upgrades on incinerators. However, DEPE is supporting the Department of Health's view that pathologic waste should be incinerated. DEPE has been supporting the retrofit of hospital incinerators with advanced air pollution control technology, including efficient particulate control, acid gas control with alkaline spray dryer and baghouse, continuous monitoring of emissions, and sufficient stack height.

Members of the Medical Society of New Jersey's Committee on Environmental Health, which has been monitoring DEPE activities, would like to see greater hospital emphasis on reducing excess waste. For example, hospitals tend to overuse disposable linens and other commodities. As major purchasers of individually packaged items, health care providers could induce suppliers to reduce unnecessary packaging.

To limit air emissions, DEPE recently announced that it would attempt to establish a numeric limit on mercury, based on best-available control technology (BACT). There are no numeric limits at present, and DEPE Commissioner Scott Weiner vetoed an effort by Camden County to set a relatively low limit. DEPE's approach to organic hydrocarbons, which are ozone precursors, is to ratchet emissions down through such mechanisms as vapor recovery at gasoline stations.

MSNJ ACCREDITATION PROGRAM APPROVED

A full four-year approval, the maximum allotted, was awarded to the Medical Society of New Jersey (MSNJ) by the Committee on Review and Recognition (CRR) of the Accreditation Council for Continuing Medical Education. In a November 4, 1991, approval letter, CRR stated that MSNJ's "staff and its Committee on Medical Education should be commended for all their efforts. . . ." The MSNJ Committee on Medical Education accredits hospitals' continuing medical education programs. Committee members involved in the CRR application included: Palma E. Formica, MD, chairperson; David E. Swee, MD, vice-chairperson; Bernardo Toro-Echague, MD, past-chairperson; and William Vaun, MD, representative of the University of Medicine and Dentistry.

SPECIAL REPORT: AMA STRATEGY ON THE NEW MEDICARE PHYSICIAN PAYMENT SYSTEM

The following letter and information are from James S. Todd, MD, executive vice-president of the American Medical Association (AMA):

The final regulation on the new Medicare resource-based relative value scale (RBRVS) payment system has been released. We at the AMA have heard your concerns and will respond to them by expanding and refocusing our advocacy efforts.

Please read the short-term action plan to initiate the AMA's RBRVS strategy for 1992. We will aggressively seek legislative and regulatory relief and will help physicians cope with the new payment system. Your input will help us maintain an effective long-term strategy on RBRVS.

We are very aware that the new payment system will require procedural changes in physicians' offices. As you can see from the action plan, we intend to undertake a major educational effort to help physicians and their patients adjust to the new system.

In response to the AMA's concerns, the Health Care Financing Administration (HCFA) has announced a one-month "grace period" for physicians to switch to the new visit codes. For services provided in January 1992, carriers will pay for all claims that use the old visit codes. Nevertheless, physicians should shift to the new payment system quickly because making the change is in their financial interests.

We at the AMA are encouraged by the improvements in the RBRVS payment system that we were able to achieve over the past six months. We believe that we can achieve additional improvements if we can maintain the momentum and cohesiveness that developed on this issue. Taking the long view, we still believe that RBRVS will be a far better payment system than the other alternatives, such as physician DRGs or capitation.

We have come through the first skirmish of an ongoing battle. We achieved some, but not all, of our objectives. Be assured, the AMA has just begun to fight.

AMA ACTION PLAN FOR RBRVS IMPLEMENTATION

During the next several months, AMA will focus and expand its activities on the new Medicare physician payment system. The AMA will emphasize assistance to members as well as legislative and regulatory relief. Specific elements of the AMA plan are as follows:

Assistance to Members.

- Conducted "Train the Trainer" workshops for Medicare carrier and Federation staff.
- Distributed informational slide presentation and text.
- Distributed informational video and video newsletter.
- Distributed revised version of the AMA's computerized RBRVS impact worksheet.
- Sponsor regional workshops on the new system to respond to problems once implementation has begun.
- Sponsored, jointly with HCFA, a national teleconference on RBRVS implementation issues.
- Published the two-volume book, *Medicare Physician Payment Reform: The Physician's Guide.*
- Published comprehensive Medicare guide with Commerce Clearing House.
- Conduct special session, "Untangling the RBRVS," at the 1992 National Leadership Conference.
- Distribute *Physician Payment Update* bimonthly.
- Distribute CPT books, expand development of clinical examples, and publish CPT supplement.

Legislative/Regulatory Relief.

- Develop consensus on legislative and regulatory priorities based on input from state, specialty, and group practice advisory committees.
- Intensify lobbying and grassroots activities to: restore payments for EKG interpretations (HR–3373 and S–1810); eliminate new physician cuts (HR–1898 and S–1810); and increase payments for assistants at surgery.
- Develop 1993 recommendation for Medicare MVPS and conversion factor.
- Pursue relief on balance billing limits.
- Seek expedited adoption of new visit codes by state Medicaid agencies.
- Urge HCFA to refine geographic practice cost indices (GPCIs) for malpractice and office overhead.
- Explore new legislative vehicles for addressing outstanding RBRVS concerns with congressional allies and cosponsors.

Identify and Analyze Impacts of RBRVS.

- Disseminate technical analysis and "audit" of the implementation of Final Rule.
- Establish a clearinghouse to catalog, document, and disseminate information on RBRVS problems and solutions.
- Continue AMA/HCFA Task Force on payment reform implementation.
- Develop and disseminate simulations of proposed legislative or regulatory changes, e.g. elimination of new physician payment differential, restoration of EKG payment, alternative GPCI construction.
- Collect, through the Socioeconomic Monitoring System, special data on impacts of implementing RBRVS.
- Consult with Federation staff and leadership (including, Socioeconomic Policy Advisory

Group; Federation Advisory Committee to the EVP; state and specialty advisory committees).

- Monitor and assess private sector interest in adopting a Medicare-style payment system.

Programmatic Initiatives.

- Implement AMA/specialty societies' relative value updating process.
- Expand and enhance CPT editorial panel and process.

HCFA ANNOUNCEMENT

Grace Period for Use of 1991 Visit Codes. The new 1992 CPT-4 visit codes are effective January 1, 1992.

To allow physicians sufficient time to become acquainted with the new codes, the carriers will allow a one-month grace period: carriers will accept and pay all claims for 1991 visit codes with dates of service between January 1 and 31, 1992, at the 1991 payment amount; and carriers will begin to deny all assigned claims with 1991 visit codes with dates of service on or after February 1, 1992. For unassigned claims, carriers will not deny claims, but will contact the physician to obtain the correct visit code.

HCFA is providing standard remittance notice language and explanation of Medicare benefit messages to the carriers for use in informing providers and beneficiaries about use of the new CPT-4 visit codes and the grace period.

PHYSICIAN PAYMENT REFORM: THE LONG VIEW

1980s. Since the early 1980s, the AMA has taken an aggressive leadership role in the search for an acceptable and equitable approach to paying for physician services furnished to Medicare patients.

1983. By 1983, with the start of DRG payment for hospitals, it was clear that Medicare's "customary, prevailing, and reasonable" (CPR) physician payment system would not long survive. With Medicare's problem of rapidly rising hospital costs apparently "solved," policymakers turned to physicians.

1984. Senator Bob Dole declared 1984 the "year of the physician," but he was not handing out congratulations. It was clear that the next round of Medicare payment changes would be directed at physicians. The Reagan Administration and Congress intensified the search for alternatives to CPR, which they blamed for the rapid growth in federal outlays for Medicare physician payments in an era of growing budgetary strain. The Administration focused on a wholesale shift from fee-for-service to "packaged" payment methods that controlled both price and volume. They were deadly serious, making a series of legislative and administrative proposals for physician DRGs and mandatory capitation, both of which would have included mandatory assignment. At the same time, a physician payment schedule based on a new relative value scale (RVS) also emerged as a viable "reform." Unlike other proposals, the AMA and much of organized medicine believed that such a schedule could preserve fee-for-service, protect physician's clinical autonomy, maintain patient access to quality medical care, and eliminate much of the complexity that increasingly plagued CPR. This complexity and the payment distortions across specialties and geographic areas had created widespread dissatisfaction among physicians. The Association had concluded that change was not only inevitable; it was desirable.

1984 to 1988. In 1984, the AMA met with HCFA and specialty societies to explore development of a RVS for Medicare. Given the growing concern within the AMA House of Delegates with the payment inequities underlying CPR, the AMA focused on a resource-based RVS—RBRVS—that would reflect the resource costs of providing physician services, i.e. physician work, overhead, and professional liability insurance costs. Citing antitrust considerations, HCFA decided not to contract with a medical society. The AMA did reach an agreement with Professor William Hsiao at Harvard University as a subcontractor in his HCFA-funded RBRVS study. This arrangement allowed for extensive involvement by organized medicine through both the AMA and over 20 specialty technical consulting groups whose members were nominated through the AMA by specialty societies. Three months after the final report of Phase I of the RBRVS study was released, the AMA's House of Delegates adopted the position at its 1988 Interim Meeting that data from the Harvard study, when sufficiently expanded, corrected, and refined, would provide an acceptable basis for a Medicare payment schedule. The House also adopted detailed policies on such implementation issues as protection of balance billing, geographic payment differentials, and Medicare expenditure controls.

1988. Immediately following the 1988 Interim Meeting, the AMA began advocating its positions on payment reform before the PPRC, Congress, HCFA, and the White House. In its April 1989 Report to Congress, PPRC joined the AMA in supporting a Medicare physician payment schedule based on a refined Harvard RBRVS.

1989. Medicare physician payment reform legislation was passed in fall 1989 as part of the Omnibus Budget Reconciliation Act of 1989 (OBRA 89). This legislation mandated that a five-year transition to an RBRVS-based payment schedule begin in 1992. It reflected compromises by all parties concerned: physicians, patients, Congress, and the administration.

Largely through the efforts of the AMA and the Federation, the bill that emerged accomplished three primary goals: (1) it would implement a completed and re-

fined RBRVS in a manner generally consistent with AMA policy; (2) it did not include mandatory assignment; and (3) it did not have a rigid expenditure target. The AMA's support for a completed RBRVS has helped stave off physician DRGs and mandatory capitation for nearly ten years.

1990 to 1991. Since OBRA 89, RBRVS has had two additional phases. Many, although certainly not all, of the concerns raised by the AMA in 1988 have been addressed. Both HCFA and the AMA have committed to continuous RBRVS refinement and updating. Likewise, after an unprecedented campaign over proposed conversion factor reductions, the medical profession has secured a conversion factor that gives the new system a fighting chance. Finally, HCFA has begun to implement comprehensive standardization and simplification of the payment policies administered by its carriers.

1992. In sum, the AMA continues to believe that payment reform still will benefit physicians and their patients. The new system will be simpler and more uniform than the current system, will be implemented through a transition that minimizes disruptions to physicians and their patients, and will provide needed relief for rural and primary care services.

STATEMENT OF THE BOARD OF TRUSTEES ON MEDICARE RBRVS IMPLEMENTATION

1. RBRVS requires substantial improvements in many of its key elements.

2. The AMA cannot affirmatively endorse the Medicare implementation of RBRVS until substantial improvements are made.

3. Preliminary review suggests the level of reimbursement for many codes and regions is inadequate.

4. The AMA will continue to pursue aggressively a fair and just reimbursement formula for all physicians and their patients by correcting and alleviating errors in the final schedule.

BOARD OF TRUSTEES' REPORT AAA: FINAL RULE ON THE NEW MEDICARE PHYSICIAN PAYMENT SYSTEM
(Reference Committee A)

Following are the recommendations of Report AAA of the Board of Trustees as adopted by the House of Delegates:

1. That the AMA take the position that the RBRVS-based Medicare physician payment schedule requires substantial improvements in many of its key elements and that the AMA cannot endorse this new system until substantial improvements are made.

2. That the AMA publicize and seek to extend HCFA's grace period on the new visit codes an additional two months until April 1, 1992, that it continue its comprehensive program to educate physicians on the proper use of these codes, and that it work to ensure that HCFA engages in only educationally oriented profiling and review of the usage of these new codes until at least July 1, 1992.

3. That the AMA undertake an immediate analysis of the implementation of the new Medicare payment schedule, with a focus on whether carrier implementation is consistent with Medicare law and HCFA regulations, especially with regard to calculation and application of the adjusted historical payment basis, and that the AMA take whatever steps are needed to correct and alleviate errors in the final schedule.

4. That the AMA reaffirm and continue efforts in support of its policy to prevent any further reduction of the current Medicare limiting charges, i.e. balance billing limits of 140 percent for evaluation and management services and 125 percent for all other services.

5. That the AMA seek a second Medicare participation decision period between June 1 and July 1, 1992, to allow physicians to reconsider the decision that they were forced to make in December 1991 on the basis of often limited information.

6. That the AMA expand its efforts to seek replacement of the current flawed proxy data basis for Medicare's GPCIs with current data that reflect actual practice overhead costs, that the AMA work to ensure that the professional liability component of both the GPCIs and RBRVS more accurately reflects the actual cost experience of the physicians providing services to Medicare beneficiaries, including specialty-level differences in these costs.

7. That the AMA assign a continued high priority to legislative correction of grossly inequitable elements of Medicare physician payment policy as the lack of any payment for interpretation of EKGs, discriminatory payment reductions for "new" physicians, unfounded payment limits for the services of assistants-at-surgery, definition of "new" patients, and the discriminatory 50 percent copayment for mental illnesses.

8. That the AMA establish a comprehensive program to monitor changes in patient access, physician practice patterns, and errors in carrier implementation under the new Medicare physician payment schedule, working closely with state and county medical societies, and that the AMA work with HCFA to correct all identified deficiencies in this program.

9. That the AMA seek to achieve adequate funding for Medicare carriers as they implement RBRVS.

10. That the AMA work with HCFA and the national medical specialty societies to clarify HCFA's new global payment policy and to disseminate accurate information to physicians on these policies.

11. That the AMA Board of

Trustees study and report to the House on the status and background of the "behavioral offset" and the "baseline adjustment" with an emphasis on the history of the use of these adjustments in Medicare Part B, including application to the RBRVS conversion factor and the MVPS.

12. That the AMA intensify its Payment Reform Education Project to provide all possible assistance to physicians as they adjust to and cope with the new Medicare payment schedule and that it evaluate the initial implementation of the new payment system, soliciting input from the entire Federation, and commenting to HCFA as part of the 120-day comment period on the relative values for the new system and as otherwise appropriate.

MEDICAL WASTE PROGRAM IN PLACE

The New Jersey State Department of Environmental Protection and Energy (DEPE) now has a program to regulate medical waste. In general, with the exception of home self-care programs, anyone generating medical waste in diagnosis, treatment, immunization, or medical research must: register with DEPE and pay designated fees; separate sharps, fluids, and other medical waste; use only transporters that are registered with DEPE (except for generators of small amounts who transport their waste to hospitals or other generators); and complete the generator's portion of waste tracking forms plus monthly logs and an annual report due July 21 of each year on a form supplied by DEPE. There also are other requirements.

DEPE has supplied the following answers to some frequently asked questions: Generators may have waste collected at any time interval, although the waste must be properly stored. Proper storage includes the use of containers that are rigid, leak proof, impervious to moisture, and resistant to tears, punctures, and breaks. Regulated body fluids include blood, cerebrospinal, synovial, pleural, peritoneal, and pericardial fluids, plus semen, vaginal secretions, dialysate solution, and amniotic fluid. Hospitals may not pick up medical waste from private practitioners' offices off-site. Some telephone numbers to keep on hand: Tracking and logging forms and information on registration or other requirements may be obtained by calling 1/609/530-8599. To obtain a list of approved transporters, call the DEPE Bureau of Registration at 1/609/530-4004. Possible violations by transporters should be reported to DEPE Inspections and Investigations at 1/609/584-4250.

LOW PEER REVIEW ORGANIZATION SANCTION RATES

During the second quarter of 1991, only 12 cases reviewed by The Peer Review Organization (PRO) of New Jersey led to sanction letters. This translates to a rate of 0.08 percent of the total of 15,461 case reviews. No cases were reported to the State Board of Medical Examiners. This lean result suggests that The PRO review of physician performance is not cost effective. The PRO did deny 81 hospital admissions and a total of 4,725 days of continued hospital stays during the three-month period.

MEDICAL BOOK COLLECTING

Bibliophilia and medical history will be the theme of a program presented on May 19, 1992, by the Medical History Society of New Jersey at its Annual Meeting to be held at the Nassau Club in Princeton. W. Bruce Fye, MD, has been selected to deliver the Annual Morris H. Saffron Lecture. His address is entitled, "Medical Book Collecting and Scholarship: Past, Present, and Future."

Papers also will be presented by Francis P. Chinard, MD, "Bibliophilia or Bibliomania? A Case Study"; Estelle Brodman, PhD, "Enough Responsibilities for All: Collectors, Book Dealers, and Librarians"; and Thomas A.

Horrocks, MA, MS, MLS, "A Quiet Lover of Books: Dr. Samuel Lewis of Philadelphia and His Library." Two informal talks will be given by Ira M. Rutkow, MD, DrPH, "Experiences of a Book Collector and Surgical Historian," and Richard P. Wedeen, MD, "A Historic Find: Charcot's Gift to Lancereaux."

For registration and information, please contact Lisa Swartek, Medical History Society of New Jersey, Two Princess Road, Lawrenceville, NJ 08648, 1/609/896-1717.

ADVANCE DIRECTIVES FORM AVAILABLE FROM COMMISSION

A booklet containing forms for people to use in developing advance directives is available from the State Bioethics Commission, CN-061, Trenton, NJ 08625. Enclose a self-addressed 9" x 12" envelope with $1 postage. The forms include: instructions on when to use life-sustaining treatments; appointment of a health care proxy to make decisions about life-sustaining treatment; and combined form with instructions and appointment. Although other, simpler forms also are available, these forms, accompanied by explanations, were produced by the Commission, which developed the state law that took effect January 7, 1992.

AMA TRUSTEE VISITS WITH NEW JERSEY PRESS

As part of an American Medical Association (AMA) campaign to sensitize news media to medical concerns about health care financing and public health, Robert E. McAfee, MD, of the AMA Board of Trustees held an editorial board conference with Trenton's *The Times* on November 26, 1991. Dr. McAfee also visited with the Camden *Courier-Post* and diverse radio stations. He later reported that the AMA's views were "well received."

NEW SEMINAR PROGRAM ON RBRVS

Seminars on handling coding problems and other RBRVS-related changes are being cosponsored by the Medical Society of New Jersey (MSNJ) and NJUP Plus, a subsidiary of the New Jersey Hospital Association. The seminars will involve interactive education techniques geared mainly to physicians' office personnel. Besides learning how to adjust to the new federal resource-based relative value scale (RBRVS) system, participants will be eligible to telephone the trainers for assistance at no charge for three months following the program. Fees are $95 for MSNJ members and their employees, and $150 for nonmembers. Call 1/609/936-2200 for details. Scheduled dates and locations are:

February 19—MSNJ offices, Lawrenceville
March 5—MSNJ offices, Lawrenceville
March 11—Sheraton, Eatontown
March 18—Hilton, Parsippany
April 8—Marriott, Seaview
April 22—Ramada Inn, Clark

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PROFESSIONAL LIABILITY

MALPRACTICE CASES

Child's Death from Brain Tumor. Several physicians—including pediatricians, pediatric gastroenterologists, and a psychiatrist—won a verdict from a New Jersey jury in a case involving a brain tumor that went undiagnosed for two and one-half years before the patient died at age ten. The defendants used a narrative, prepared by the patient's mother in her own handwriting, to undermine her claim that she never had been advised to obtain a complete neurologic workup. Her case may have been hurt further by the large number of defendants whose factual accounts she disputed. There also was evidence that, on the day of her daughter's death, she asked whether she could wait before taking the child to the hospital emergency department as directed.

Hyperalimentation of Young Mother. A general surgeon lost a case before a New Jersey jury that centered on the question of whether the surgeon had properly relocated a hyperalimentation catheter after an x-ray revealed it to be either in the right atrium of the heart or in the inferior vena cava. A pathologist testified on the plaintiff's behalf that fluid found in the pericardial space was hyperalimentation fluid that could only have been present if the catheter was indeed misplaced. Photographic blowups of hospital records, showing that the surgeon may have advised that the procedure should commence even though the catheter was in the inferior vena cava, lent further support to the plaintiff's claim.

The jury awarded $200,000 for the patient's hour-long pain and suffering. An additional $606,000 was awarded for the economic loss to the patient's three-month-old baby. The patient was a 21-year old Peruvian immigrant with an extended family and low earnings.

Psychiatric Patient's Death. A consulting internist lost a $322,000 New Jersey verdict in the death of an obese, 47-year-old manic depressive admitted to a hospital by a psychiatrist for an adjustment of lithium. Noting shortness of breath and edema of the extremities, the psychiatrist ordered a chest x-ray and blood gas studies. The x-ray was not taken, and the studies came back abnormal. A series of internists did not take followup action, and, according to nurses, the unsuccessful defendant did not respond when told the patient could not be roused, an account disputed.

Damages reflected the patient's $15,000 salary as a casino dealer in Atlantic City, the housework he performed as his wife also worked outside the home, and the presence of a 17-year-old son.

Neurosurgeon Liability. A patient, who at age 14 had the area of his congenital A-V malformation surgically clipped, experienced a rupture of the malformation 13 years later that left him paralyzed on the left side. Other neurosurgeons testified that, under the standard of care at the time of the surgery, the entire malformation should have been removed. The plaintiff further contended that the defendant neurosurgeon was negligent in failing to take an angiogram ten years later, when the patient complained of numbness in the left side.

Under a jury verdict in New Jersey, the plaintiff would receive $1,375,000 from the defendant for failing to take the angiogram. The claim relating to the original surgery was settled before trial. The jury decided that each of the two instances of alleged negligence contributed 50 percent to the patient's damages, which the jury assessed at $2,750,000. As a result of his injuries, the patient had to leave a $37,000-per-year job and move in with his mother, who performs support services for him at an estimated value of $15 per hour.

Orthopedic Care. An orthopedic surgeon won a New Jersey jury verdict in a case involving a comminuted fracture of the middle finger. The plaintiff contended that the surgeon should have performed an open reduction or used a "buddy" system in which the adjoining finger serves as a brace. The defendant countered that: an open reduction was unnecessary; the buddy system had been used; and the patient failed to undergo surgery recommended by several physicians.

MALPRACTICE CASES IN OTHER JURISDICTIONS

Oncologists Not Diagnosticians. After two pathologists issued a diagnosis of lung cancer and a third pathologist referred the tissue to a fourth such specialist, an oncologist initiated chemotherapy. The fourth analysis established a negative finding. No negligence by the oncologist, ruled a Missouri appeals court: oncologists are not diagnosticians.

Loss of Nurse's Note. If a hospital's loss of a lengthy nurse's note resulted from reckless disregard for the note's relevance to the malpractice case, the trial judge should have instructed the jury that it could conclude that the note was unfavorable to the hospital, ruled the U.S. Court of Appeals for the District of Columbia, sometimes called the second highest court in the land.

The note was written by a nurse who was present at a problematic delivery. Several efforts at a forceps delivery by the attending obstetrician proved unsuccessful and may have damaged the baby, who grew to suffer from cerebral palsy and other health problems. Eventually the delivery was performed by an obstetrician employed by the hospital. The attending physician settled the claim, and the hospital and its employed physician won at trial, in the absence of the suggested jury instruction. The Court of Appeals remanded the case for a ruling on the issue of reckless disregard.

Breast Cancer Screening. Even though a physician should have ordered mammography screening of a patient who subsequently died of breast cancer, the physician was cleared of malpractice in a jury verdict affirmed by a Superior Court in Pennsylvania. The failure to screen was not a substantial factor in the patient's death, decided the jury.

Death of a Jehovah's Witness. The patient's refusal of a necessary blood transfusion does not automatically excuse the physician of liability for the patient's death, ruled an Illinois appeals court. Complications arose from surgery to remove polyps from the colon. The complications, including bleeding, were noted for almost two weeks before the transfusion was recommended as a last resort. Negligence could have led to a failure to diagnose and treat the complications on a timely basis, said the court, which noted that any ensuing award for damages could be reduced to the extent that the patient's decision contributed to his death.

Failed Sterilization. Because a woman gave birth after undergoing a laparoscopic tubal ligation to become sterile, she may sue the hospital for breach of warranty and bring an action for malpractice. However, she may not recover damages for the birth of a child, a Pennsylvania Superior Court has determined.

Wrongful Birth. From Kansas comes word that parents of a child may recover for "wrongful birth" from physicians who failed to advise them properly about the potential for birth defects. The criteria for wrongful birth, according to the state Supreme Court, include: severe and permanent disability; defects that could have been determined before birth; the defendant's duty to the parents to perform the tests; and a failure to perform the tests or to perform them properly.

Liability for Harm Done by Patient on Steroids. Reversing an earlier decision, the Supreme Court of Indiana has ruled that a physician treating a patient with anabolic sterioids owed no duty to unidentifiable third parties. The patient, a longtime user of the steroids, allegedly became a toxic psychotic and shot two people, killing one of them. The wounded person sued the doctor. But, said the court, the physician could not foresee that the drugs would put the patient "... in such a state that he would use a weapon to cause harm to another." Moreover, the court added, liability in such a case would be "unacceptable" because it would force a physician "to weigh the welfare of unknown persons against the welfare of his patient."

Res Ipsa Loquitur. When circumstances obviously indicate that the plaintiff's injury resulted from the defendant's negligence, the burden of proving whether negligence occurred shifts from the plaintiff to the defense. This doctrine, res ipsa loquitur, recently received a full review by the U.S. District Court in Vermont.

After exploratory surgery for infertility, a woman suffered permanent loss of function in one leg. She contended that the injury must have resulted from negligent use of a self-retaining retractor used to expose the field of operation. After the trial judge refused to instruct the jury in res ipsa loquitur, the jury returned a verdict in favor of the defense. The federal court ordered a new trial, due to experiences that indicate that an injury of this sort occurs only because of negligence.

Proximate Cause. Whether the defendant's negligence caused the plaintiff's injury was at issue in a case involving a fatal neurologic injury at birth. The trial court instructed the jury to find sufficient causation if, in the jury's opinion, the injury would not have occurred "but for" the defendant's conduct. On appeal, the Idaho Supreme Court reversed the judgment due to evidence that the injury might have occurred anyway. The proper instruction, said the court, involved deciding whether the defendant's negligence was a substantial factor in causing the injury.

HEALTH CARE FINANCING

Congress Told About Successes in Other Countries. A November 1991 report by the General Accounting Office (GAO), the investigative arm of Congress, supports broad and enforced budget controls as a way of holding down health care costs. Ordered by the late Senator John Heinz (R-PA), the GAO report focuses on experiences in France, Germany, and Japan and may inform debates about health care financing during the 1992 election campaign and beyond.

All three study countries spend less on health care per capita than the United States, and all have compulsory insurance financed by employer and employee payroll contributions that are calculated on the basis of large cross-sections of the population. The French, Germans, and Japanese enjoy comprehensive benefits mandated by law. Their national systems also include multiple insurers and no payment deductibles. These features avoid the thorny problems of uninsurance and underinsurance, cost shifting among payers (as occurs in New Jersey, where Medicare and Medicaid pay less than private insurers), HMO-type restraints on patients' choice of a physician, and uncertainty about whether a particular insurance plan will cover a particular service.

Unlike fee schedules, broad budget controls on physician or hospital services limit both prices and volume, the twin dimensions of expenditures. According to GAO researchers, France has effectively negotiated spending limits with each hospital, and Germany has effectively set caps on physician services, also through negotiation. By contrast, unenforced targets on hospital expenditures in Germany were less effective.

Some limitations of these findings may be useful to critics of budget controls: The findings focus only on the two European countries, and GAO refrained from making any recommendations. In a footnote, the authors commented that a uniform pricing system, advocated by supporters of national health insurance, could reap substantial administrative savings, but only as a one-time-only gain. They further recognized that budget controls do not limit expenditures caused by aging of the population, prices of prescription drugs, or inefficiencies that could be resolved by incentives for greater efficiency or by closing inefficient hospitals.

A further limitation is this important caveat by the authors: "The singleminded and sustained pursuit of spending containment through the use of targets and caps may, however, harm quality." There also is a methodologic limitation, because the caps that were found successful in Germany were in place for only two full years—which is not much time for collecting trend data—and were associated with actual decreases in expenditures for physician services when the goal was a moderate increase.

Safe Harbors. In a detailed review of Medicare safe harbors, Aspen Publication's December 1991 *Hospital Law Newsletter* concludes: "The real problem is that the government does not have a formula that defines relationships of structures that, by definition, are categorically abusive and damage the Medicare program." Even the rule permitting as much as 40 percent of the equity in a health care investment to be owned by people in a position to make referrals is not a clear standard, according to the review, because the Inspector General contends that hospitals and not just practitioners are in a position to make referrals.

MALPRACTICE POLICY DEVELOPMENTS

The Canadian Experience. Canadian physicians are sued for malpractice about one-fifth as often as physicians in the United States and pay premiums about one-ninth the amount of stateside premiums, according to a study reported in *The New England Journal of Medicine*. Possible reasons for Canada's success include a cap on awards for pain and suffering, payment to attorneys based on time rather than contingent fees, and adherence to the British rule requiring losers in a law case to pay most of the winner's costs. Even with these advantages, though, Canadian physicians experienced a sevenfold increase in malpractice claims between 1971 and 1989.

Insurance Investigation Drama. New Jersey has provided part of the setting for a law-enforcement investigation that, according to *Medical Liability Monitor*, "reads like a script for a made-for-TV movie." The Bramson brothers, Leonard and Martin, were indicted in Newark in September 1991 on 29 counts of mail and wire fraud, extortion, money laundering, and conspiracy, connected with the formation of fraudulent malpractice insurance companies and solicitation of insureds. After allegedly ignoring a court cease-and-desist order, the brothers were arrested out-of-state, but Martin later cut off an electronic monitoring bracelet and jumped bond.

Senate Hearings. Robert E. McAfee, MD, of the AMA Board of Trustees testified in favor of tort reform before a Senate Finance Committee subcommittee chaired by John D. Rockefeller (D-WV) in October. The senators heard suggestions to replace malpractice litigation with a hospital-financed compensation system based on strict liability, or with a system of "accelerated-compensation events," involving a list of adverse outcomes that ordinarily occur only when there is negligence. Senator Pete Domenici (R-NM) advocated his own proposal for mandatory arbitration and a cap on awards for pain and suffering.

Alabama Cap Struck Down. The Supreme Court of Alabama is the latest tribunal to rule a cap on noneconomic damages (pain and suffering) unconstitutional. Rights to a jury trial and equal protection, both enshrined in the state constitution, were found to be violated by a cap that does not appear to hold down malpractice premium rates. Another law, requiring periodic payout of

damages, also was struck down by the court for reasons involving the right to jury and the functions of juries when the state constitution was adopted.

Colorado Arbitration Plan. To halve legal fees through arbitration, a Denver insurance expert is attempting to develop an insurance product in his state. According to Larry G. Dick and his American Liability Group, Inc., premiums could drop under his proposal by 15 to 30 percent.

MALPRACTICE LIABILITY TIPS

Termination of Services. To avoid charges of abandonment, physicians should not delegate to their staffs any decision to stop seeing a particular patient, and should provide proper written notice of termination and proper attention to the medical problem under treatment and any medical crisis. *Loss Minimizer* further suggests that, if it is the patient who terminates the relationship, the physician should telephone to discuss the reason or write to acknowledge the patient's decision and discuss the reason. The publication further advises informing the liability carrier if the reason is dissatisfaction with the care, and taking seriously any complaints about staff discourtesy and waiting time.

Spinal Cord Injuries. Improvements in the transport of trauma victims and in emergency department diagnosis and treatment are leading to better prognoses for patients with spinal cord injuries. Some suggestions from *Personal Injury Newsletter* include:

1. Keep splinting in place until x-rays have been completed or spinal shock has resolved. Cases of spinal cord injury in intoxicated, unconscious, or spinal shock patients sometimes are not identified.
2. Assure visualization of all seven cervical vertebrae in lateral cervical x-rays. Also, obtain full spinal x-rays.
3. To reduce edema, inflammation, and ischemia when the neurologic status is abnormal, administer steroids either intravenously or intramuscularly every four to six hours.
4. If the patient has a bony fragment, disk material, or a hematoma impinging on the spinal cord, indicating a partial cord lesion, surgery can achieve maximum benefit if performed within approximately two hours.

AIDS ISSUES

Inmate Not Told of HIV Positivity. A federal district court in eastern Virginia has decided that a prison physician, but not a community hospital, was acting on behalf of the state and, therefore, could be subject to liability under Sec. 1983 of the Civil Rights Act for an alleged failure to inform an inmate that the inmate had tested positive for HIV. The Reconstruction-era statute permits claims for state actions that violate civil rights.

During a visit to a hospital emergency department, the inmate was tested. The physician's liability would depend in part on whether the physician actually was informed of the test result. The court permitted the civil rights action to be brought by both the inmate, who was paroled without ever being informed of the test or the result, and his wife, who later tested seropositive.

HOSPITAL PRIVILEGES

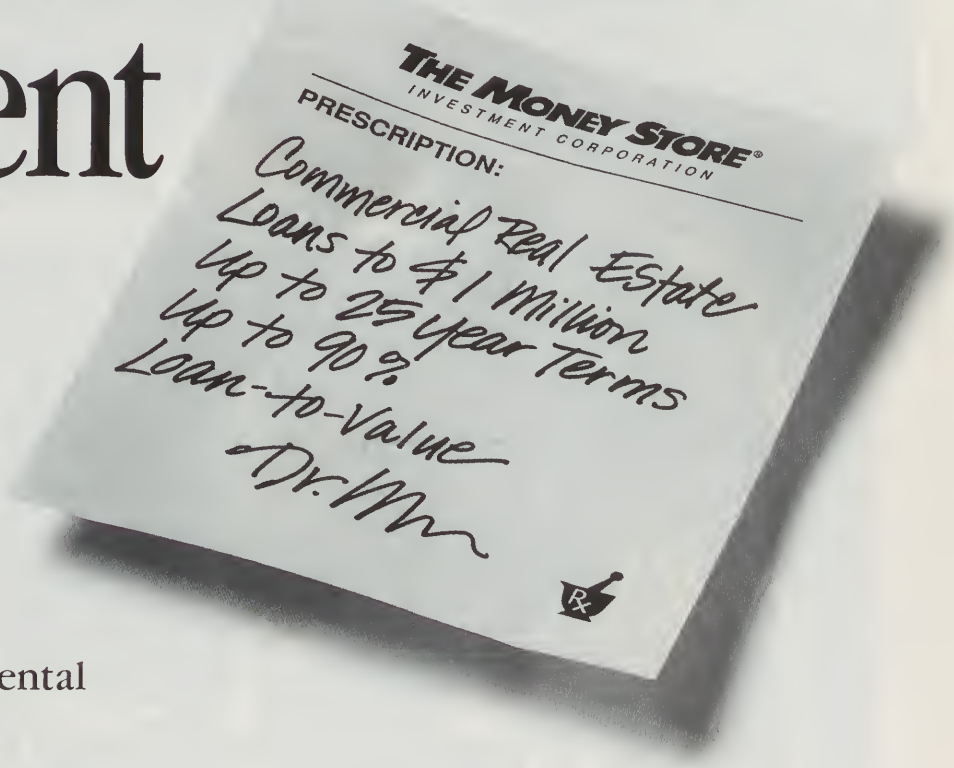
Cardiac Surgery. A hospital violated its bylaws in permitting an ad hoc committee to terminate the elective cardiac surgery privileges of a much-questioned physician, the Utah Supreme Court has held. An award of $150,000 was upheld despite evidence that the physician's income rose after the termination.

When the committee informed the physician of the pending termination, the physician did not respond; when the termination actually was handed down, the physician did not object. The termination reflected a 30-percent mortality rate and the refusal of anesthesiology and perfusion personnel to work with him. Earlier, the physician's surgical privileges had been reinstated when he obtained focused medical education during a moratorium imposed by the committee.

PROFESSIONAL LIABILITY

James E. George, MD, JD, director of Professional Liability Control, and Neil E. Weisfeld, JD, MSHyg, director of Education, Research & Regulatory Affairs, supplied this commentary on behalf of the Medical Society of New Jersey. □

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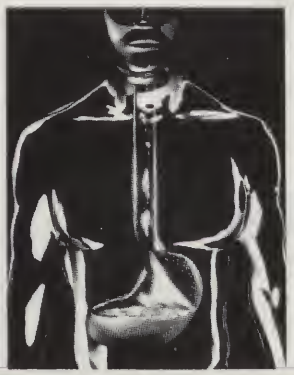
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Indications and Usage: 1. *Active duodenal ulcer*– for up to 8 weeks of treatment at a dosage of 300 mg h.s. or 150 mg b.i.d. Most patients heal within 4 weeks.

2. *Maintenance therapy*– for healed duodenal ulcer patients at a dosage of 150 mg h.s. at bedtime. The consequences of therapy with Axid for longer than 1 year are not known.

3. *Gastroesophageal reflux disease (GERD)*–for up to 12 weeks of treatment of endoscopically diagnosed esophagitis, including erosive and ulcerative esophagitis, and associated heartburn at a dosage of 150 mg b.i.d.

Contraindication: Known hypersensitivity to the drug. Because cross sensitivity in this class of compounds has been observed, H_2-receptor antagonists, including Axid, should not be administered to patients with a history of hypersensitivity to other H_2-receptor antagonists.

Precautions: *General*– 1. Symptomatic response to nizatidine therapy does not preclude the presence of gastric malignancy.

2. Dosage should be reduced in patients with moderate to severe renal insufficiency.

3. In patients with normal renal function and uncomplicated hepatic dysfunction, the disposition of nizatidine is similar to that in normal subjects.

Laboratory Tests–False-positive tests for urobilinogen with Multistix® may occur during therapy.

Drug Interactions–No interactions have been observed with theophylline, chlordiazepoxide, lorazepam, lidocaine, phenytoin, and warfarin. Axid does not inhibit the cytochrome P-450 enzyme system; therefore, drug interactions mediated by inhibition of hepatic metabolism are not expected to occur. In patients given very high doses (3,900 mg) of aspirin daily, increased serum salicylate levels were seen when nizatidine, 150 mg b.i.d., was administered concurrently.

Carcinogenesis, Mutagenesis, Impairment of Fertility–A 2-year oral carcinogenicity study in rats with doses as high as 500 mg/kg/day (about 80 times the recommended daily therapeutic dose) showed no evidence of a carcinogenic effect. There was a dose-related increase in the density of enterochromaffin-like (ECL) cells in the gastric oxyntic mucosa. In a 2-year study in mice, there was no evidence of a carcinogenic effect in male mice, although hyperplastic nodules of the liver were increased in the high-dose males as compared with placebo. Female mice given the high dose of Axid (2,000 mg/kg/day, about 330 times the human dose) showed marginally statistically significant increases in hepatic carcinoma and hepatic nodular hyperplasia with no numerical increase seen in any of the other dose groups.The rate of hepatic carcinoma in the high-dose animals was within the historical control limits seen for the strain of mice used. The female mice were given a dose larger than the maximum tolerated dose, as indicated by excessive (30%) weight decrement as compared with concurrent controls and evidence of mild liver injury (transaminase elevations). The occurrence of a marginal finding at high dose only in animals given an excessive and somewhat hepatotoxic dose, with no evidence of a carcinogenic effect in rats, male mice, and female mice (given up to 360 mg/kg/day, about 60 times the human dose), and a negative mutagenicity battery are not considered evidence of a carcinogenic potential for Axid.

Axid was not mutagenic in a battery of tests performed to evaluate its potential genetic toxicity, including bacterial mutation tests, unscheduled DNA synthesis, sister chromatid exchange, mouse lymphoma assay, chromosome aberration tests, and a micronucleus test.

In a 2-generation, perinatal and postnatal fertility study in rats, doses of nizatidine up to 650 mg/kg/day produced no adverse effects on the reproductive performance of parental animals or their progeny.

Pregnancy–Teratogenic Effects–Pregnancy Category C–Oral reproduction studies in rats at doses up to 300 times the human dose and in Dutch Belted rabbits at doses up to 55 times the human dose revealed no evidence of impaired fertility or teratogenic effect; but, at a dose equivalent to 300 times the human dose, treated rabbits had abortions, decreased number of live fetuses, and depressed fetal weights. On intravenous administration to pregnant New Zealand White rabbits, nizatidine at 20 mg/kg produced cardiac enlargement, coarctation of the aortic arch, and cutaneous edema in 1 fetus, and at 50 mg/kg, it produced ventricular anomaly, distended abdomen, spina bifida, hydrocephaly, and enlarged heart in 1 fetus. There are, however, no adequate and well-controlled studies in pregnant women. It is also not known whether nizatidine can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Nizatidine should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers–Studies in lactating women have shown that 0.1% of an oral dose is secreted in human milk in proportion to plasma concentrations. Because of growth depression in pups reared by treated lactating rats, a decision should be made whether to discontinue nursing or the drug, taking into account the importance of the drug to the mother.

Pediatric Use–Safety and effectiveness in children have not been established.

Use in Elderly Patients–Healing rates in elderly patients were similar to those in younger age groups as were the rates of adverse events and laboratory test abnormalities. Age alone may not be an important factor in the disposition of nizatidine. Elderly patients may have reduced renal function.

Adverse Reactions: Worldwide, controlled clinical trials included over 6,000 patients given nizatidine in studies of varying durations. Placebo-controlled trials in the United States and Canada included over 2,600 patients given nizatidine and over 1,700 given placebo. Among the adverse events in these placebo-controlled trials, only anemia (0.2% vs 0%) and urticaria (0.5% vs 0.1%) were significantly more common in the nizatidine group. Of the adverse events that occurred at a frequency of 1% or more, there was no statistically significant difference between Axid and placebo in the incidence of any of these events (see package insert for complete information).

A variety of less common events were also reported; it was not possible to determine whether these were caused by nizatidine.

Hepatic–Hepatocellular injury (elevated liver enzyme tests or alkaline phosphatase) possibly or probably related to nizatidine occurred in some patients. In some cases, there was marked elevation (>500 IU/L) in SGOT or SGPT and, in a single instance, SGPT was >2,000 IU/L. The incidence of elevated liver enzymes overall and elevations of up to 3 times the upper limit of normal, however, did not significantly differ from that in placebo patients. All abnormalities were reversible after discontinuation of Axid. Since market introduction, hepatitis and jaundice have been reported. Rare cases of cholestatic or mixed hepatocellular and cholestatic injury with jaundice have been reported with reversal of the abnormalities after discontinuation of Axid.

Cardiovascular–In clinical pharmacology studies, short episodes of asymptomatic ventricular tachycardia occurred in 2 individuals administered Axid and in 3 untreated subjects.

CNS–Rare cases of reversible mental confusion have been reported.

Endocrine–Clinical pharmacology studies and controlled clinical trials showed no evidence of anti-androgenic activity due to nizatidine. Impotence and decreased libido were reported with similar frequency by patients on nizatidine and those on placebo. Gynecomastia has been reported rarely.

Hematologic–Anemia was reported significantly more frequently in nizatidine than in placebo-treated patients. Fatal thrombocytopenia was reported in a patient treated with nizatidine and another H_2-receptor antagonist. This patient had previously experienced thrombocytopenia while taking other drugs. Rare cases of thrombocytopenic purpura have been reported.

Integumental–Urticaria was reported significantly more frequently in nizatidine- than in placebo-treated patients. Rash and exfoliative dermatitis were also reported.

Hypersensitivity–As with other H_2-receptor antagonists, rare cases of anaphylaxis following nizatidine administration have been reported. Rare episodes of hypersensitivity reactions (eg, bronchospasm, laryngeal edema, rash, and eosinophilia) have been reported.

Other–Hyperuricemia unassociated with gout or nephrolithiasis was reported. Eosinophilia, fever, and nausea related to nizatidine have been reported.

Overdosage: Overdoses of Axid have been reported rarely. If overdosage occurs, activated charcoal, emesis, or lavage should be considered along with clinical monitoring and supportive therapy. The ability of hemodialysis to remove nizatidine from the body has not been conclusively demonstrated; however, due to its large volume of distribution, nizatidine is not expected to be efficiently removed from the body by this method.

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BOOK REVIEWS

CLINICAL MAGNETIC RESONANCE IMAGING

Robert R. Edelman; John R. Hesselink. Philadelphia, PA, W.B. Saunders, 1991. Packed with extensive, practical information, this state-of-the-art, clinical review of magnetic resonance imaging (MRI) makes a salient contribution to the literature of the field. The textual emphasis on presenting as many current techniques as space will allow is commendable; indeed, even spectroscopy, still considered an experimental approach, is discussed in approximately 40 pages.

Designed to give the reader a firm, technical grasp of MRI, the first part of this volume devotes considerable space to such subjects as the use of image contrast and the MRI of flow. This latter chapter, a far-ranging exposition, highlights the cutting-edge technique of MR angiography. The contributors penchant for direct explanation results in a clear overview of the field.

The second part of the book, which concentrates on the central nervous system, begins with a short multiplanar atlas of the brain. A concise review of white matter maturation as well as a brief but well-written exploration of such congenital malformations as heterotopic gray matter and the Chiari malformations follow. The use of intravenous gadolinium figures prominently in the chapter on neoplasms. Overall, these chapters on the brain and the spine stress the practical aspects of understanding MRI.

The heart receives ample attention in the third part of the book, with a discussion of the chest and abdomen, emphasizing the newer techniques. A review of the cardiac diseases occurs in the chapter entitled, "Examination of the Adult Heart and Great Vessels." Abnormalities involving adult manifestations of congenital heart diseases and acquired lesions are presented clearly with copious high-quality scans. Cardiac cine imaging is given its own chapter. The liver and the adrenal glands, organs often evaluated with MRI, comprise the bulk of the section on the abdomen.

Part IV takes up the musculoskeletal system, including the more common studies of the knee, hip, and shoulder.

The appendices contain a compendium of scan protocols, which should prove invaluable to the beginning imager.

This text contains a tremendous amount of information on a broad range of topics and should complement any physician's library of diagnostic volumes. The editors are to be lauded for their achievement. ☐ Neil B. Horner, MD

IMAGING OF THE HEAD, NECK, AND SPINE

Richard E. Latchaw (ed). St. Louis, MO, Mosby Year Book, 1991. In the original printing of this text, published in 1985, Dr. Latchaw endeavored to review the pathophysiology involved in the computed tomography (CT) interpretation of neuroradiology. Since that time, magnetic resonance imaging (MRI) has become the imaging modality of choice for the field. Therefore, while the first publication, covering only CT, could fit into one volume, this edition, *MR and CT Imaging of the Head, Neck, and Spine,* has been expanded into two volumes to accommodate a wider array of contributors. This thoroughly researched, well-written examina-

tion of MR and CT imaging reflects the rising importance of MRI to the field of neuroradiology but the authors still consider the value of CT where appropriate.

The opening chapters analyze the physics of MRI and survey the properties of contrast agents. A brief anatomical atlas follows. The first clinical section assesses the diseases of the brain. The common and esoteric elements involved in pediatric diseases receive extensive attention; however, the section on white matter maturation was brief.

Nowhere is the difference between the two editions more evident than in the sophisticated detail presented on the head and neck in the second edition. The chapter on the temporal bone stands out as an example of lucid writing that guides the reader through a complex subject by providing a firm clinical basis as well as by making frequent crossovers between CT (the dominant image modality here) and MRI when necessary. As a rule, the chapters consider comparisons between CT and MRI relevant findings, as well as clinical and pathological correlation. The images are plentiful and first rate in quality.

After studying this text, the reader will have a bird's-eye view of all areas of neuroradiology. I have no doubt this edition will surpass its highly accomplished predecessor in popularity. ☐ Neil B. Horner, MD

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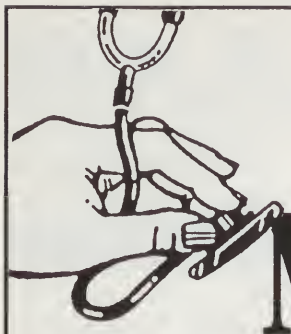
Samuel Broder, MD (ed). Baltimore, MD, William and Wilkins, 1991. Knowledge of molecular biology provides new opportunities to expand our understanding of cancer and to develop new methods of treatment that, based on rational principles, carry the promise of greater success. The purpose of this book is to present the major molecular concepts needed to impart this knowledge. Written for individuals lacking extensive background in molecular biology, it provides a broad perspective of current research efforts in the field.

Developments addressed include: the genetic and molecular basis of cancer and the identification of families of genes, both oncogenes (that accelerate) and suppressor genes (that retard), that influence tumor cell growth; the characterization of physiologic growth factors and their receptors; and the identification of genes and protein products that regulate metastatic growth, perhaps leading to the capacity to block certain critical steps in the metastatic process, thus providing novel new therapies.

Insights to be gained by the reader include: how cells evade the effects of various cancer drugs, leading to the development of new strategies to reduce drug resistance and improve activity of available chemotherapies; mechanisms of natural biological substances such as T cell growth factors, the various interleukins and other cytokines, and their potential applications; and the many ways in which genetically engineered products, including monoclonal antibodies, can be used to treat patients with cancer.

Concepts also explored are the use of recombinant DNA technologies to introduce foreign genes into appropriate cells, providing opportunities to understand fundamental aspects of prevention, diagnosis and treatment; and further elucidation of new families of viruses, particularly the human retroviruses involved in certain lymphoproliferative states and AIDS.

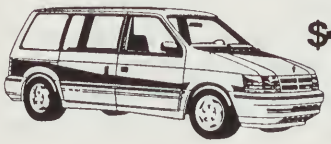
Dr. Broder and 49 other outstanding scientists present an exciting overview of research that promises to carry progress in cancer forward through the 1990s and into the next century. ☐ Alan J. Lippman, MD



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EDITOR'S DESK



THE ORIGINAL UNTOUCHABLES

Leprosy, a disease of antiquity, has been known as Hansen's disease for many years, solidifying the premise developed by Mr. Paul Mange in this issue of *NEW JERSEY MEDICINE* (pages 118-121) as to the rightful discoverer of the cause of that unfortunate condition.[1] Yet leprosy still is a disease in the shadows and the word "leper" still connotates one who is shunned by polite society—despite the development of effective pharmaceuticals that arrest the course of illness.

According to Ida, a leprosy patient on Molokai, as quoted by Crawshaw[2], 15 million people in the world are leprosy sufferers and the numbers are growing; Hawaii gets its share from the Philippines, and the continental United States is getting an influx from Vietnam. (The true number of those affected worldwide may be closer to 10 to 12 million. Most are located in southeast Asia, central Africa, India, and parts of South America.) Ida also said, "Caucasians have little experience with leprosy and leprosy is a disease of poor nutrition and ignorance." These statements are open to question.

Wood[3] pointed out that leprosy, so prevalent in history into the Middle Ages, died out in most of northern Europe but recurred in epidemic proportions in Norway—a Caucasian country where Hansen discovered the *Mycobacterium leprae* and where extensive demographic and epidemiologic studies were done. Wood noted that the true cause of the rise and the subsequent fall in the incidence of leprosy in Norway has not been explained satisfactorily, but four of the reasons proposed are:

"1. Isolation of infective cases in the early stages.
2. Emigration to the United States of a high-risk population of young and presumably infected patients.
3. Improved nutrition as part of improved living standards.
4. The protective role of cross immunity to tuberculosis."[3]

Wood does not examine item number 2, nor does he discuss the importance of isolation of early cases.[2] However, Mange notes Hansen's imposition in 1885 of regulations to isolate leprosy patients, by force if necessary; the drop in numbers of those afflicted after that was ascribed to these measures and leprosaria were its natural successors.[1]

Considerable detailed investigation was made of the living conditions in Norway, in areas of both high and low incidence of leprosy. Although some of the large families, crowded and confined during inclement weather, could have been at increased risk for the spread of disease, this was far from proved. And the Norwegian people, even in poor communities, were self-sufficient and self-reliant, with reasonably decent hygiene and a surprisingly adequate, nutritious, and balanced diet. In Norway, at least, leprosy did not appear related to poor nutrition and living standards in the 19th century. Whether this is true today in the leprosy-prone areas of the world is another matter.

Wood's article also speculates about the possible reciprocal relationship between two mycobacteria, *M. tuberculosis* and *M. leprae*.[3] Socioeconomic factors were similar in both, but the incidence of tuberculosis increased simultaneously with the decrease of leprosy. There also was an apparent antithetical geographical relationship; tuberculosis was scarce where leprosy flourished, while leprosy was minimal where tuberculosis was rampant. Other, more modern evidence of cell-mediated

cross immunity also was presented.

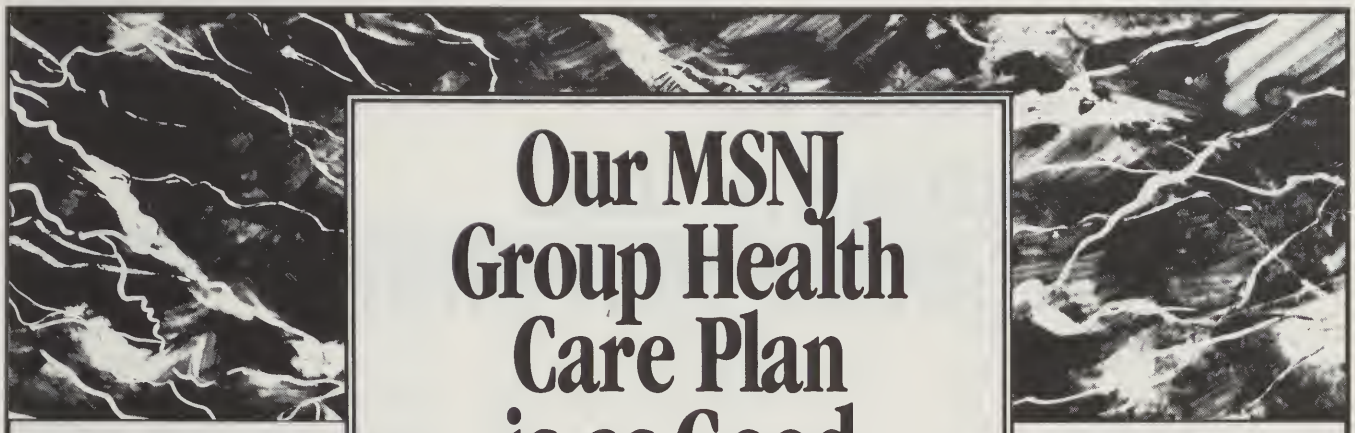
The treatment of leprosy is fairly straightforward. Although transmission probably is via the respiratory tract, isolation is deemed unnecessary because of the rapidity of action of therapeutic agents, initiated in 1941 with glucosulfone. Primary agents today include dapsone, rifampin, and clofazimine for therapy and it is postulated that a single large dose of rifampin, given by necessity to an entire community, could act as a preventative agent. Bacillus Calmette-Guérin vaccine (BCG) also has shown prophylactic qualities against the tuberculoid type—another example of the relationship between tuberculosis and leprosy. A vaccine is being studied.

Despite the advances over the last century, leprosy, the hidden disease, has not emerged into the full light of understanding. But full understanding of disease is not needed for reasonable understanding of the patient. As Crawshaw put it so eloquently, "Do not extinguish the patient while removing his or her pain. As I have come to believe Ida would have it, patient and physician together strive for full feeling in body, mind, and spirit, together become children of promise, sharing all suffering, enduring all things, alive to all life."[2]

> *All interest in disease and death is only another expression of interest in life.*
>
> Thomas Mann, *The Magic Mountain*, 1924

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Guest Editorial: Mammography and Breast Cancer Screening

Alan J. Lippman, MD

Early detection of breast cancer represents the best hope for increasing survival rates, and the most successful method for early detection is mammography. Numerous studies have established the value of mammography in breast cancer screening. In this issue, Dr. Palace shows that mammographic screening is effective in identifying earlier stage breast cancer at one community hospital in New Jersey (pages 134-136).

The first randomized controlled study of screening mammography was undertaken by the Health Insurance Plan (HIP) of New York in 1963. Women were offered annual screening by physical examination and mammography for 4 successive years. After 7 years, there was a 30 percent reduction in the breast cancer mortality rate in the women offered screening compared with those in the control group. After 18 years, the mortality rate was reduced by 25 percent.

The Breast Cancer Detection Demonstration Project (BCDDP), sponsored by the American Cancer Society and the National Cancer Institute, enrolled 280,000 women. Beginning in 1973, five consecutive annual screenings were conducted using physical examination and mammography. Mammography detected more than 90 percent of all cancers found by screening; 42 percent of the lesions were detected only with mammography. One-third of the cancers were of the noninvasive type or less than 1 cm in size, features regarded as prognostically favorable; more than 80 percent of patients failed to show axillary nodal involvement, also portending a favorable outcome.

Numerous other studies have confirmed the value of mammographic screening. Additionally, the Breast Cancer Detection Awareness Program (BCDAP) of the American Cancer Society, in cooperation with the New Jersey State Department of Health, over the past five years, has sought to provide New Jersey women with the knowledge that early detection is the most important breast cancer control strategy.

Based on such experience, the National Cancer Institute and the American Cancer Society have recommended that all women of average risk greater than age 40 receive mammograms every one to two years until age 50 and annually thereafter. Those at higher risk are advised more frequent examinations.

Despite the importance of mammography, authorities caution that supplementary procedures, including clinical examinations and self-examination, be employed due to the occurrence of false-negative mammograms in approximately 10 to 15 percent of cases. This is attributed, in part, to increased density of parenchymal tissue, unusual calcification configurations, or faulty radiographic technique.

Notwithstanding the demonstrated value of screening mammography, a number of barriers remain to deter women from participating in mammography screening. These include a fear that something adverse, in fact, will be found. Some women report not being encouraged to go for a mammogram by their physicians. Presumably, these physicians are unaware of the value of this procedure and the advances that have been made in mammographic technology resulting in safer, more productive studies.

A third barrier that may deter women from getting a mammogram is cost. In New Jersey, the average cost of screening mammography ranges from $55 to $200, although participants in the BCDAP may receive a free or low-cost mammogram at the time of their initial participation.

The cost barrier now may be overcome, thanks to recent legislation in New Jersey requiring private insurance companies and health maintenance organizations to reimburse screening mammography. New Jersey now joins 34 other states that have enacted mammography legislation.

Further efforts to overcome all of these barriers must continue. Physicians as well as patients should be educated to recognize the value of screening mammography and to overcome the prejudices of the past so that all women at risk have the opportunity of cure now clearly within reach. ■

References available upon request.

PRESIDENT 'S PAGE



THE PRESERVATION OF OUR PROFESSION

Why are we physicians? What is the heart and soul of our existence? What do all physicians have in common? The answers are easy when you think about them. We have a professional commitment to our art, to our science, and to our profession that binds us together as physicians.

Today, however, as never before, our professionalism is regularly threatened by competitive forces. Articles and certain innuendoes are appearing almost daily in the news media and in journals, attacking the very nature of our professionalism. These assaults are gradual and subtle. They are dangerous because they strike at the heart of who and what we are. These attacks are driven by persons who, for one reason or another, envision medicine as a mere trade, a business venture, or a socialized utility. They wish to reduce the profession of medicine to a less respected level.

Critics and regulators have managed to have physicians called "providers" and patients called "consumers," and have placed layers of red tape between the two. Perhaps unconsciously, we are letting them get away with it. How many times will they call us providers—or vendors—or entrepreneurs—before we start thinking that we are?

Why is professionalism so important and what can we do to preserve it? Professionalism has three essential elements that we must strive vigorously to maintain and protect.

First, professionals have a vast body of knowledge to master and to continually update. Since its founding in 1847, the American Medical Association (AMA) has been instrumental in setting standards for medical education; and the AMA continues to upgrade public health and foster high standards of medical care.

Second, our profession sets a standard of behavior for its members that is more stringent than the standards set by a trade or the law. This standard is called medical ethics. As the nation's first state medical society, established in 1766, the Medical Society of New Jersey (MSNJ) is a leader in enhancing and encouraging ethical behavior in our profession.

Third, professionalism is based on a special relationship between the physician and each patient that he serves. This almost sacred relationship places the interest of the patient above all other considerations. We must treat patients with compassion and share in our hearts the burdens that they carry. By caring, we must lighten that burden when possible, even when that is all that can be done. This is the hallmark of the medical profession. This is why we exist.

An appreciation for caring is one reason why each of us chose medicine as a career. In my case, an incident involving my grandmother influenced my choice: A little girl got sick at school, and was sent home by the teacher. While walking the railroad tracks to get home, she fainted. A train came and ran over her legs. My grandmother, working in a nearby field, quickly tore her apron apart and used the strips to stop the bleeding. She held the little girl in her arms until an ambulance came to transport her to the hospital. She saved that little girl's life. We were so proud of our grandmother for the care that she gave.

The ability to help patients bear their burdens is an important and unique part of the doctor-patient relationship—the compassionate human connection—that has always made medicine such a wonderful, fulfilling profession.

Doctors from all over this state and this country must pull together to preserve and defend all that is good about our profession. This is a fight we cannot afford to lose. We must protect and preserve the vital, unique, treasured doctor-patient relationship. We must help doctors to improve, and patients to live healthier lives.

What can we do to preserve professionalism? The most important thing is to do what we have always done: put our patients first! Next, we must be ethical and honest, compassionate, and caring. Finally, we must belong to organized medicine—become active in county societies, MSNJ, and the AMA. We must pay our dues, not just in dollars, but also in time and talent.

We need your membership, so we can represent all physicians as we fight the ongoing battle to preserve professionalism. Join with us—in the family of medicine—so your voice can be heard. Together we will win this battle for professionalism, because we are professionals, and we are physicians. God bless! □

Joseph A. Riggs, MD

Parts of this page were excerpted, with permission, from remarks delivered to the Mercer County Medical Society on April 14, 1991, by John J. Ring, MD, president of the AMA.

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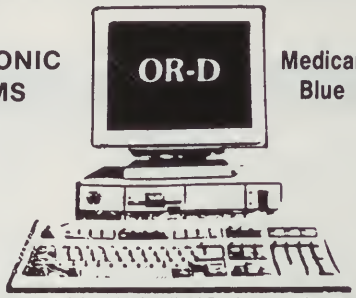
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LETTERS AND VIEWPOINTS

ALLERGY TESTING

As a member of the Medical Society of New Jersey (MSNJ), a board certified allergist and immunologist, and the medical director of the Allergy Testing Center, I am saddened and angered by the letters from Drs. Picone and Klein on the Allergy Testing Center's advertisement, and appalled by the editor's note and your failure to offer me the opportunity to respond in the same issue to those letters (*NJ MED* 88:705, 1991).

Dr. Picone's letter is the most upsetting since it is full of distortions. He states, "The implication is that other allergists do not return patients to the referring physician and that simply is not true." The reality is that allergists most often do not return patients for followup allergy care to the referring physician. The collaboration between referring physicians and the Allergy Testing Center is unique.

If one reads the advertisement this is made perfectly clear. From the 52 physicians who responded to the advertisement in *NEW JERSEY MEDICINE* and referred patients to the Allergy Testing Center, the number one reason they gave for utilizing our service was their desire to follow their patient and administer the allergy treatment after the diagnostic evaluation. Giving the patient the choice to have allergy injections from their primary care physician is more convenient and almost always less expensive.

Further, Dr. Picone wrote, "It is difficult to believe that this (the diagnostic evaluation including 84 skin tests) could be consistently accomplished." I cannot believe Dr. Picone can make such a scurrilous statement about the Allergy Testing Center, and indirectly about me. Dr. Picone never has been to our offices, has not sent us a patient, nor even called me to discuss the Allergy Testing Center procedures. What Dr. Picone should believe is the facts. Patients are consistently seen at the Allergy Testing Center in one session, in one hour, and receive complete testing, including 84 skin tests and comprehensive diagnostic evaluation. This is done in a comfortable, conveniently located office that also is economical for the patient.

Dr. Picone also states he realized that MSNJ may be legally bound to publish such distasteful advertisements and that such advertisements are a blot on everyone. MSNJ is not legally bound to publish any advertisement they feel is distasteful. The Allergy Testing Center was required to submit the advertisement to *NEW JERSEY MEDICINE* for review and prior approval. This approval was given and the advertisement was published. The advertisement by the Allergy Testing Center is not a blot on anyone but it obviously is a threat to those who do not want a change in the status quo.

Dr. Klein wrote, "If, in fact, the contention made here is true and that allergists frequently overtake the care of patients referred by primary care physicians, this reflects the patient's perception that a subspecialist is more capable of rendering a higher level of care." This may be true, however, the Allergy Testing Center is merely offering an alternative to this customary practice. The Allergy Testing Center specializes in collaborating with the primary care physician in offering their patients comprehensive allergy evaluation and care.

The editor's note is by far the most upsetting. "Editor's note. Drs. Picone and Klein are correct. MSNJ and the editorial staff do not endorse the services described in the advertisement." The editor's note does imply your blanket endorsement of Drs. Picone and Klein's remarks because Dr. Picone's letter does not address the issue of endorsement. You may not "have" to follow the common practice of publishing simultaneous "letters to the editor" and a reply because it deals with an advertisement, but would not common courtesy dictate such a policy when fellow MSNJ members criticize each other—whether it is responding to an article or an advertisement?

It is irresponsible of the editor and of *NEW JERSEY MEDICINE* to permit and endorse attacks and distortions about one member by other members. This is particularly outrageous when *NEW JERSEY MEDICINE* reviewed and approved the advertisement before it was published. ☐ Brian E. Novick, MD

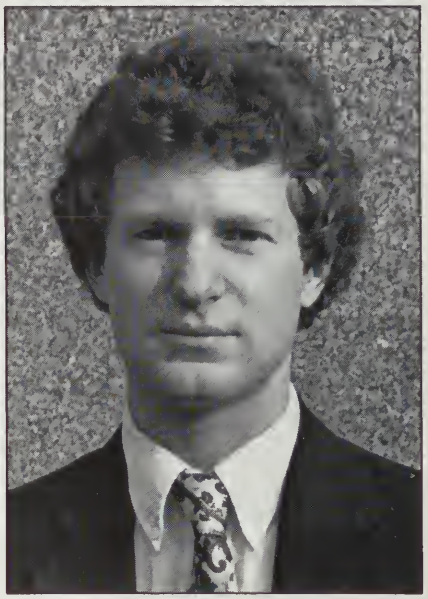
Hansen and his Discovery of *Mycobacterium leprae*

Paul F. Mange

Hansen possessed keen scientific insight and a strong personal character. These qualities were necessary to overcome many obstacles barring the path to his lifetime goal of eradicating leprosy from Norway. This paper is the 1991 winner of the Stephen Wickes Prize in the History of Medicine.

Gerhard Henrik Armauer Hansen began his work with leprosy at the Lungegaarden Hospital in Bergen, Norway, in 1868, two years after passing his medical examinations. At that time, leprosy was a major public health concern, having risen from a prevalence of 5/10,000 in 1836 to 20/10,000 in 1856. The 1847 publication of a book, *On Leprosy,* by Danielssen (the chief physician at the Lungegaarden Hospital) and Boeck gave the first detailed clinical and pathological description of leprosy and "marked an epoch in the literature and the modern investigation of leprosy, and made Bergen for many years the center of leprosy studies."[1] This book was accepted as the definitive work on leprosy, as evidenced by Virchow's comment in 1864 that "earlier works about leprosy were of little scientific interest when compared to that by Danielssen and Boeck."[2] Despite his eminence in the international scientific community, however, Danielssen was to come under attack from a young man working within his own laboratory. It was Hansen who eventually would demonstrate the failings of Danielssen's ideas on leprosy, and lead the world's thinking toward a more accurate view of the true nature of leprosy. That he was able to do so while under Danielssen's supervision is ample indication of Hansen's remarkable perseverence and confidence in his abilities (Figure 1).

Danielssen and Boeck concluded that leprosy was mainly a nonspecific hereditary affliction, a "dyscrasia of the blood," a belief that Danielssen carried with him to the grave in 1895. Because their opinions carried much weight, the initial attack on leprosy was designed according to Danielssen and Boeck's philosophy: sexual isolation was viewed as the most effective means of combating the spread of the disease. Danielssen, thus, recommended that lepers be secluded in hospitals and that they be prohibited from marrying.[3] Danielssen's view was supported by the Academy of Medicine in London, which reported that leprosy was unquestionably a hereditary disease.[4] In response to questions concerning the spread of leprosy, Dr. W.E. Nourse, in 1862, declared, "Leprosy is considered in Norway to be undoubtedly hereditary, and to be perpetuated and increased



Paul F. Mange

there by lepers marrying and having children . . . I have met with no instance of leprosy communicated by contagion."[5]

A vocal minority of scientists attributed the spread of leprosy to a host of other causes. Dr. J. L. Bidenkap, Hansen's pathology tutor, for example, held that leprosy was neither specific nor hereditary, and he was supported in his belief by Dr. J. J. Hjort, who in 1832 had conducted extensive epidemiologic studies on leprosy in Norway. H. Holmsen, a District Health Officer, agreed that leprosy was not hereditary, but thought that its cause was specific and miasmatic. Lochmann, one of Hansen's professors at the University of Christiana believed that leprosy was mostly hereditary, but was occasionally contagious.[6] Another view held

simply that leprosy arose spontaneously of its own accord.

During the first few years of his tenure as Chief Medical Officer for Leprosy, L. G. Hoegh believed that leprosy arose from poor living conditions and excessive toil. After careful examination of the Leprosy Registry, a medical innovation he created in 1856 containing detailed information on every known leper in the country, Hoegh modified his view, concluding in 1858 that leprosy was an infectious disease. In 1869, Drognat-Landre wrote, "Their illness was caused by infectious contact with leprosy patients."[7] Thus, the idea of leprosy as an infectious disease was not altogether new when Hansen began his investigations. What led him to adopt the views of a small segment of researchers, despite the prevailing scientific opinion that leprosy was a hereditary disorder?

To answer this question, we must look at the personal characteristics of Hansen. Norwegian scientists were familiar with current research in other parts of the world, so Hansen likely knew of Snow's studies in the 1850s on cholera in England. Hansen later adopted Snow's method of carefully examining the course of disease in every affected person. Similar field studies were carried out by the Norwegians, C. H. Homan, Jr, and C. H. Hartwig, on dysentary in 1859 and on typhoid fever in 1865, respectively.

Hansen had an exceptionally critical mind. In concluding his first paper on leprosy in 1870 he wrote, "One can produce examples that support one view and examples that support another, and others that support a third view, yet none of them is convincing."[7] He knew of the many opinions concerning the cause of leprosy, but rather than blindly agreeing with the leading authorities on the matter, Hansen sided with those who reached their conclusions after a more thoughtful examination and contemplation of the data.

In 1872, Hansen wrote that Drognat-Landre's book had first convinced him that "infectiousness was not paid sufficient attention by us [in Norway]."[2] However, he was years ahead of his time in his conviction that leprosy was not only specific and infectious, but caused by a bacterium. The field of bacteriology was in its infancy during Hansen's early life; Koch and Weigert did not develop their staining techniques until six years after Hansen had first seen the leprosy bacillus. Furthermore, at that time only a handful of diseases had been shown to be caused by specific microbes: muscardine in silkworms, favus (severe ringworm of the scalp), anthrax in sheep and cattle, tuberculosis, and relapsing fever.[8] Hansen was well aware that no chronic disease had yet been demonstrated to be caused by bacterium. The major bacterial discoveries were not made until after Hansen had established the presence of the leprosy bacillus: gonorrhea, typhoid fever, cholera, diphtheria, and tetanus.[1] It took Hansen many years to become convinced he had found the bacterial cause of leprosy. Considering that he had no electric light and used only a simple microscope and primitive staining techniques, it is a testament to Hansen's exceptional insight and self-confidence that eventually he succeeded.

Hansen and Danielssen had a unique relationship that extended beyond the boundaries of science. On January 7, 1873, one month before his discovery of *Mycobacterium leprae,* Hansen married Danielssen's daughter, Stephanie Marie. Danielssen demonstrated his fondness for Hansen quite clearly in 1880 after Neisser published his controversial paper proclaiming his discovery of *Mycobacterium leprae.* Although Hansen was calm in response to the article, "Danielssen was furious and scolded me for my indolence when anybody tried to steal my discovery."[6] In his



Figure 1. Gerhard Henrik Armauer Hansen in 1873.

memoirs, Hansen described Danielssen with respect and understanding. "While he believed in testing to the limit the work of others, he could be defensive about his own. This is not an uncommon trait. When one has concluded a particularly exhausting study and arrived at a finding it is very difficult to abandon it even if it encounters arguments that are strongly—even convincingly—against it ... Time can only tell how I would react if the main thinking of my life were challenged."[9]

Ironically, when later asked about the date of his discovery, Hansen wrote, "Indeed I am not sure myself when I first saw the bacillus of leprosy; it was in 1870 or 1871, not 1872. I sent my report to Christiana, but the report was not published until 1874."[4] On the contrary, there is ample evidence that his discovery was in 1873. Had he indeed seen the bacillus in 1871, why would he have spent 1871 and 1872 collecting extensive case histories of 69 families exhibiting leprosy in western Norway? Second, Vogelsang determined from Hansen's family that he submitted his paper to the Norwegian Medical Society in the fall of 1873, and not earlier, as Hansen stated in his letter. The Society considered his paper so important that they published a separate

volume of the *Norsk Magazin for Laegevidenskaben* devoted entirely to Hansen's findings. Given their enthusiasm for his findings, they presumably would have published it as soon as possible; the paper came out in 1874. Finally, the first mention of the leprosy bacillus outside of Norway appeared in a paper by the English surgeon, H. V. Carter, who visited the leprosy asylums during August and September 1873. In his statement to the secretary of state of India in November 1873, Carter mentioned that "Dr. G. A. Hansen of Bergen is engaged in a series of inquiries which cannot but throw much light upon the origin and nature of leprosy. These point to the parasitic origin of the disease; and by Dr. Hansen's kindness I have myself seen the minute organisms (a species of *Bacterium*) which are present in living leprous matter taken from the interior of a 'tubercle.' "[10]

Adding to the cloud of confusion surrounding Hansen's discovery of *Mycobacterium leprae,* in 1880, 24-year-old Albert Neisser demonstrated the microbacterial origin of gonnorhea. He then published another paper claiming to have been the first to identify the bacillus of leprosy. Neisser had travelled to Norway in summer 1879, and "through the extraordinary courtesies of the Norwegian scholars saw all the cases of leprosy in the hospitals in Trondheim, Molde, and Bergen, about 600 in number. We studied the possibilities of origin and course of individual cases, and left with the impression of a noncontagious process, something on the order of a constitutional lupus or a syphilis as Virchow interpreted them. Hansen's personally demonstrated preparation of motile bodies had not convinced us of the presence of bacteria."[11] Knowing that Neisser worked with Weigert, Hansen, who had been unsuccessful on previous attempts to stain the bacteria, had hoped that Neisser could help him with Koch and Weigert's new staining techniques. Neisser was unable to produce results. Hansen, therefore, provided Neisser with 14 samples of leprous nodules to bring back with him to Breslau for further analysis. Soon afterwards Neisser stained the bacteria, and in 1880 reported, "To my intense surprise I found everywhere bacilli in large numbers, in all 14 pieces of skin and nodules, in the liver, spleen, testes, lymph nodes, and cornea. These rods appeared to be something previously unknown."[10] Neisser believed he was the first to attach these specific bacteria to the disease of leprosy, and thus felt that he had priority over Hansen in this discovery because Hansen had not been fully convinced that what he had seen was in fact the bacillus of leprosy.

The confusion was due in large part to Hansen's exceptionally critical interpretation of what he saw. In his 1874 report, in which he first mentioned the rod-like bodies, he concluded cautiously, "I have now prepared my topic from all aspects which I at present feel to be involved in it. Everywhere I find conditions which speak in favor of the specificity of leprosy, nothing whatever which distinctly speaks against it, and absolutely nothing which speaks in favor of nonspecificity."[10] A second factor contributing to the ambiguity of who first sighted the leprosy bacillus was that all of Hansen's papers were written in Norwegian, and were thus not widely read. With the strong encouragement of Danielssen, Hansen responded to Neisser's announcement by writing a second paper, published in Norwegian, English, and German. In the introduction Hansen stated, "I am making this report now, partly to maintain my priority in the matter before a scientific public larger than the Scandinavian alone, and partly to bring my work up to date with additional details omitted from the 1874 report to the Medical Society of Christiana because of the then incompletely proven results."[11] In this report, however, Hansen added little new knowledge about leprosy, whereas a followup report in 1881 by Neisser "must be acknowledged as an outstanding definitive description of the relations of the bacilli to the lesions and of their etiologic import."[11] Because the micro-organisms Neisser observed turned out to be the cause of leprosy, and because Hansen had given him both the idea and the tissue samples themselves upon which his work was based, Hansen must be considered the rightful discoverer of *Mycobacterium leprae.*

Although Hansen and Danielssen disagreed about the etiology of leprosy, they did share the belief that human innoculations were of utmost importance in determining the nature of leprosy. Hansen felt that it was of critical importance to determine whether the more infectious nodular form of the disease could be induced in a patient with the less contagious macroanesthetic form of the disease. Toward this end, on November 3, 1879, Hansen performed an operation on a patient who had been in the hospital for over 15 years: he sliced her conjunctiva with a knife that recently had been used to remove a nodule from the skin of another patient. Hansen failed to obtain the patient's consent and had caused her considerable pain and anxiety. He, therefore, was charged with misuse of his office and found guilty on May 31, 1880. His trial raised a heated debate in the Norwegian scientific community, and many distinguished men came to Hansen's aid.

Hansen's punishment was somewhat of a compromise. On April 17, 1880, over a month before a decision on the case was given, the Government adopted two proposals drawn up by the Ministry of Justice, effectively separating Hansen's two jobs as physician at the Leprosy Hospital in Bergen and as Chief Medical Officer for Leprosy in Norway. In

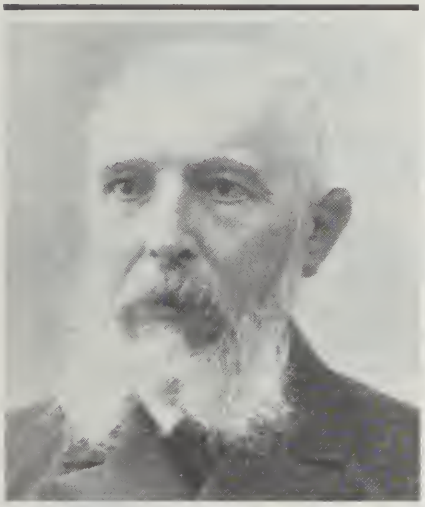


Figure 2. Hansen, in 1910.

sentencing Hansen, the court held that "an illustrious man has to yield to obedience to the Norwegian laws and that the court has to protect every subject of the nation against encroachment from more influential individuals."[12] Since he had misused his power as a physician but not as a medical officer, the court relieved Hansen of his duties as a physician, but allowed him to retain his post as Chief Medical Officer for Leprosy. The court felt Hansen had incurred the ill will of his patients and no longer would be able to effectively carry out his duties as a doctor, but "it would raise an obstacle to the solution of an important problem if Armauer Hansen were removed from his position as Chief Medical Officer for Leprosy."[13] Hansen, in characteristic form, quickly put the unpleasant incident behind him and went on with his work. In an 1885 publication, he remarked, "We cannot experiment with human beings."[13]

Hansen was criticized for accomplishing little of significance between 1874 and 1880. However, these were perhaps the busiest years in Hansen's fight to eradicate leprosy from Norway. Although he tried numerous times to prove that Henle's postulates could be successfully applied to the leprosy bacillus, every attempt failed. More important to Hansen was the struggle to apply his new knowledge to the fight against the spread of the disease. Prior to 1876, isolation of patients in leprosy hospitals was the major method used to combat the disease. Hansen stressed the importance of continuing this practice, and in 1877, he proposed legislation to further these ideas. In the May 26th "Act for the Maintenance of Poor Lepers, etc.," Hansen called for the banning of the "laegd" system for lepers. Under this system the poor moved about Norway from one farm to another, staying at each farm for a period of about two weeks working in return for shelter and food. Hansen instead recommended that all lepers who could not provide for themselves be hospitalized. Based on the first prognosis of the spread of leprosy in Norway, Hansen proposed even stronger restrictions in 1885. The June 6th "Act on the Seclusion of Lepers, etc." called for the isolation of all lepers, either in the home, or in institutions. Although this Act met with severe opposition, because it stipulated that police force could be used if necessary to bring patients to the hospital, Hansen argued that it simply was a logical extension of the ideas of the first Act, and drew upon information in the Leprosy Registry to support the need for such measures.

Public outcry soon died away after the public witnessed the humane manner in which these Acts were carried out, and after they observed that these regulations had a marked effect on the spread of leprosy. Although leprosy already had declined from 2,858 cases to 1,752 cases between 1856 and 1875, the incorporation of these two Acts caused an even sharper decline in the following years. In 1896, St. Jørgen's Hospital stopped admitting new leprosy patients, and in 1912 the Pleiestiftelsen for Spedalske Nr. 1 was converted into a hospital for tuberculosis patients.[14] By 1895, there were 688 cases nationally, dropping to 577 cases in 1900, and to 326 cases in 1910, just two years before Hansen's death. The trend continued through the middle of this century: there were 160 cases in Norway in 1920, 60 cases in 1930, 28 cases in 1940, 11 cases in 1950, and 7 cases by 1957,[12] leading R. S. Melsome, Norway's last Chief Medical Officer for Leprosy, to resign. Although part of the decline in the spread of the disease can be attributed to the improved living conditions and economic welfare of all Norwegians, the majority of the credit must go to Hansen for his tireless effort to stamp out leprosy (Figure 2).

CONCLUSION

Throughout his life, Hansen demonstrated a strong will that allowed him to face the many obstacles placed in the path to gaining acceptance of his views on leprosy. Hansen's faith lay in his firm belief in science: he fought mainly for the unbiased interpretation of the facts that led him to his conclusions. Although outspoken, Hansen remained a modest man, despite the international recognition he received for being the major force in acceptance of the bacterial etiology of leprosy. He honestly believed that the discovery of *Mycobacterium leprae* would have been discovered eventually by any physician with "the eagerness, intelligence, and skill."[15] Given the many challenges Hansen had to face, it is clear that he deserves much credit. Hansen demonstrated superior insight and intelligence in his 44-year struggle to elucidate the cause of leprosy and to eradicate it. ■

Mr. Mange is a medical student at the University of Massachusetts Medical School, Worcester, Massachusetts. For a complete study of Hansen, Mr. Mange was the recipient of the 1991 Stephen Wickes Prize in the History of Medicine awarded by the Medical History Society of New Jersey. Requests for reprints may be addressed to Mr. Mange, 50 Plantation Street, Apartment 1B, Worcester, MA 01604. References available upon request.

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Digestive System Complications in AIDS Patients

Anand M. Gupta, MD
Hidenori Kawanishi, MD, PhD

We studied 202 patients with acquired immunodeficiency syndrome (AIDS) and found only 43 patients with digestive system complications. The current study supports the view that the workup of AIDS patients with gastrointestinal complaints should be limited.

By July 1990, 140,822 cases of acquired immunodeficiency syndrome (AIDS) had been reported to the Centers for Disease Control (CDC), and 270,000 cases in total are expected to be reported by the end of 1991; an estimated 0.5 to 3 million persons currently are infected with HIV,[1] making AIDS one of the most important health problems of this decade. Involvement of the gastrointestinal (GI) tract in AIDS patients is frequent: In the course of their illness, 50 to 93 percent of AIDS patients have digestive system complications.[2,3] Chronic diarrhea, the most common symptom in AIDS patients, has been reported in 50 to 90 percent of all AIDS patients.[4,5]

However, our clinical experience in the care of AIDS patients in New Jersey did not appear to support such a high incidence of digestive system complications. Thus, we have attempted to determine the actual incidence of digestive diseases and to assess the diagnostic workups in AIDS patients in our central New Jersey institution, and to formulate regional health care needs and management protocols for these patients.

PATIENTS AND METHODS

We reviewed the medical records of 202 patients with AIDS admitted to University Hospital from January 14, 1984, to June 30, 1990 (including multiple admissions of the same patients). Forty-three patients (25 percent) were found to have digestive system-related diagnoses on admission and/or on discharge. At the time of admission, all patients belonged to group IV of the revised CDC case definition of AIDS,[6] and presented with one or more of the following criteria (confirming the diagnosis of AIDS, as per stage 6 of the Walter Reed staging classification): presence of HIV antibody; opportunistic infection (as per the CDC guidelines); anergic to four test antigens conventionally used; and a T-helper cell count less than 400 per mm^3.[7]

RESULTS

Of the 202 patients reviewed, only 43 patients had GI complications. Thirty-nine patients were adults and four patients were children (under 13 years of age). The average age of the adult patient was 33.7 years [standard deviation (SD) was 6 years]; the age range was 25 to 60 years. As shown in Table 1, two-thirds of the patients were black. Three-fourths of the white patients were male, and over half of the black patients were male. Over half of the patients were intravenous drug abusers; almost one-fourth of the patients (23 percent) were homosexual or bisexual men. As for the proportion presenting other risk factors for AIDS, 9 percent of the patients had parents with or at risk for AIDS, 4 percent of the patients had heterosexual contact with HIV-infected persons, 2 percent of the patients had hemophilia, and 7 percent of the patients had no identifiable risk factors. The mean lymphocyte count was 586.6 per mm^3 (SD was 483.2 per mm^3); 88 percent of the patients (38 of the 43 patients) were lymphocytopenic, i.e. had absolute lymphocyte count less than 1,000 per mm^3. However, all of the patients had a documented low CD4 count or a reversed T4/T8 ratio.

The average weight of the adult patient was 90 percent (SD was 6 percent) of the mean ideal weight for patients of comparable height, age, and sex; however, the range was 61 to 124 percent. Pediatric patients averaged 74 percent of the mean ideal weight for patients of comparable age and sex, i.e. had a mean weight loss of 26 percent; SD was 17 percent. Mean hemoglobin was 9 gm% (SD was 2.7 gm%) and mean serum albumin was 2.7 gm/dl (SD was 0.8 gm/dl).

Table 1. *Demographic characteristics.*

Race	Sex		Number (%)
	Male	Female	(n=43)
Black	15	12	27 (63)
White	11	4	15 (35)
Hispanic	1	0	1 (2)

Diarrhea was the most common complaint, being present in 20 of the 43 patients; other complaints are indicated in Table 2. As noted in Table 3, only half of the patients had a diarrhea history adequately detailed in the chart, two-thirds of the patients had stool studies, and one-third of the patients had no workup done at all. A definitive diagnosis could be made only in one-third of these patients. Table 4 indicates the etiology of the diarrhea in those patients given a definitive diagnosis. Enteric pathogens included *Shigella* (1 patient), *Campylobacter jejuni* (1 patient), and *Clostridium difficile* (1 patient), whereas nonenteric pathogens included *Candida* (3 patients), cytomegalovirus (1 patient), and *Mycobacterium avium intracellulare* (1 patient). Three patients received antibiotics for enteric pathogens found in their stools.

Oral thrush was present in 37 patients (86 percent). Esophagitis was present clinically (based on a history of dysphagia and/or odynophagia with oral thrush present) in 10 patients (23 percent); esophagogastroduodenoscopy with biopsy was performed in 7 of these patients and was diagnostic in 6 patients, all of whom showed esophageal candidiasis. One biopsy indicated the presence of both *Candida* and herpes simplex. One patient had presented with upper GI bleeding due to candidiasis. Two patients presented with abdominal pain; those patients were diagnosed with acute pancreatitis (etiology unknown) on the basis of increased serum amylase, but there was no further workup. Upper GI bleeding was a presenting complaint in 2 patients; 1 patient had severe candidiasis and the other patient had duodenitis without any evidence of bleeding found at endoscopy. Lower GI bleeding was seen in 3 patients; 1 of these patients had coagulopathy, whereas the other 2 patients were not worked up (1 patient died prior to any workup). Oral ulcer, present in 3 patients, was due to cytomegalovirus in 1 patient and was nondiagnostic (on biopsy) in 2 patients. Three patients had anal ulcers, all due to herpes simplex. Four patients had anal fistula without any evident etiology. Perirectal abscess was found in 1 patient, where a growth of multiple organisms including normal bowel flora was documented.

Thirteen patients (33 percent) were found to have abnormal liver function tests at the time of presentation or during hospitalization. Significant alkaline phosphatase elevation was documented in 10 patients, and ranged from 127 to 1,112 units/L (upper limit of normal 95 units/L); significant elevation of the transaminases, i.e. more than two times the upper limit of normal, was documented in 6 patients; and both enzymes were found to be elevated in 6 patients. Five patients had transaminases higher than alkaline phosphatase, whereas 3 patients had the reverse. Hyperbilirubinemia of 3.2 mg/dl to 6 mg/dl, with the upper limit of normal being 1.2 mg/dl, was present in 3 patients; it was direct in 2 patients and indirect in 1 patient. A hepatitis profile was performed in 3 patients; the profile was nondiagnostic due to an incomplete profile. Six patients were thought to have drug-induced hepatitis; four patients had hepatitis due to sulfonamides; and 2 patients had hepatitis due to antituberculosis medications. Seven other patients with abnormal liver function had no definitive etiology noted on their charts. Liver biopsies had not been performed.

COMMENT

Our retrospective review of AIDS inpatients showed a marked difference in the incidence of digestive system complications in these patients, as compared to other studies. Only about one-fifth of the AIDS patients admitted to our hospital had digestive system complications whereas other reports have suggested a much higher incidence of 50 to 93 percent.[2,3] This discrepancy could be attributed to significant differences in the demographic characteristics and risk profiles of the patients in our study group as compared with others. For example, two-thirds of our patients were black, one-third of our patients were female, and one-half of our patients were intravenous drug abusers. CDC has reported the AIDS population in the United States to be only 27 percent black, 61 percent homosexual or bisexual men, with a male/female ratio of 9:1.[1] The discrepancies in our study could be due to the disproportionately larger number of intravenous drug abusers, particularly females, in our study population; our small sample size; and our inclusion of inpatients only. Other reasons for the discrepancies could be the relatively different immune status of our patients associated with better nutritional conditions (the average weight was 90 percent of ideal weight), making them less prone to opportunistic digestive system complications as compared to others. In addition, the GI opportunistic pathogens that may be present less frequently in the central New Jersey area may play some role. All four pediatric patients in our study population were female,

although the male/female ratio among pediatric cases is reported to be approximately 1:1. This could simply be attributed to the sampling.

Diarrhea has been reported to be the most common complication of the digestive system in AIDS, being present in 50 to 90 percent of cases;[4,5] and infectious etiology is found in over one half of these patients.[8,9]

In our study, we found diarrhea in 47 percent of the cases, and only one-third of these patients had a definitive diagnosis. Although *Cryptosporidium* is the most frequently reported protozoal pathogen (found in 15 percent of those patients with diarrhea),[4,8,10] we did not encounter any such cases in our study. Among the bacterial pathogens, *Mycobacterium avium intracellulare* and *Salmonella* were the most common pathogens but other bacterial pathogens included *Campylobacter jejuni, Shigella flexneri,* and *Clostridium difficile.*[11-16] We found 1 patient each with *Shigella, Campylobacter jejuni, Mycobacterium avium intracellulare,* and *Clostridium difficile* as etiologic agents in diarrhea. Almost all patients with cytomegalovirus infection showed intestinal involvement,[17,18] with patchy or diffuse colitis resulting in diarrhea.[19] We had 1 patient with diarrhea due to cytomegalovirus infection. The presence of *Candida* may reflect a secondary colonization.[20] *Candida* was isolated from the stool in 3 of our patients with diarrhea. A National Institutes of Health study found pathogens in 17 of 20 AIDS patients presenting with diarrhea who were comprehensively evaluated.[10] Others have suggested, however, that idiopathic diarrhea in AIDS patients is due to immunologic injury to the lamina propria of the small intestine and colon.[21]

The lower incidence of esophagitis (23 percent) found in our group of patients could have been due to their use of prophylactic topical antifungal agents, their less severely deficient immune statuses, and the fact that relatively few of our patients underwent endoscopy. Varying incidences of candidal esophagitis have been noted by others, with an incidence of 93 percent in Haitian men[8] and 40 percent in homosexual men.[22] Another study has reported an association of oral thrush with candidal esophagitis of nearly 100 percent.[23] We found oral thrush in 8 percent of cases, but esophagitis was present clinically in only 23 percent. Cytomegalovirus and herpes simplex type 1 may cause severe odynophagia.[24,25] We found anorectal disease less frequently, probably because there were relatively few homosexual men in the study and only a relatively small number of patients were studied. Homosexual AIDS patients are particularly prone to a number of anorectal diseases. One-third of the patients in a reported series of 340 AIDS patients were found to have anorectal disease—most commonly perirectal abscesses, anal fistulae, and proctitis.[26]

Acute GI complications were found relatively infrequently in our AIDS patients: five patients had GI bleeding, three patients had lower GI bleeding, and two patients had upper GI bleeding. Other published reports also have indicated a relatively low incidence of GI bleeding in AIDS patients.[27,28]

Although one-third of our patients had some liver function abnormalities, less than one half of these patients had a definite etiology mentioned, which was drug-induced hepatitis due to sulfonamides in our series. The high incidence of allergy to sulfa in AIDS patients may be related to our finding of drug-induced hepatitis in many of these patients.[29] In over one-half of the patients, no clear reason for high liver enzymes could be found, but no complete hepatitis profiles, imaging procedures, or liver biopsy had been performed, as they were not considered to be significant for clinical management. Acute or chronic hepatitis B is very rare in AIDS patients. *Mycobacterium avium intracellulare* is the most frequently found hepatic pathogen, occurring in 19 to 70 percent of patients.[30] Liver biopsy specimens from AIDS patients almost always are abnormal; Kaposi's sarcoma is seen in 10 to 15 percent and cytomegalovirus is seen in 5 to 25 percent of cases.[17,31] Imaging procedures are essential early in the workup, when jaundice and hepatomegaly are present.[31-33] In intrahepatic disease in AIDS patients, a marked alkaline phosphatase elevation has been correlated statistically with *Mycobacterium avium intracellulare* infection.[32] In our series, liver biopsies were not performed in patients with elevated alkaline phosphatase, hence, we were unable to confirm this finding. In any event, our cases did not require histological findings for proper management of the liver function abnormalities observed. We believe that a liver biopsy is needed in AIDS patients with abnormal liver function tests

Table 2. *Gastrointestinal-related chief complaints.*

Complaint	Number of Patients (%)
Diarrhea	20 (47)
Dysphagia	10 (23)
Anorectal complications	8 (19)
Gastrointestinal bleeding	5 (12)
Oral ulcer	3 (7)
Abdominal pain	2 (5)
Abnormal liver function	13 (30)

Table 3. *Evaluation of diarrhea.*

	Number of Patients (%)
Appropriate history documented	9 (54)
Stool studies (2 or more cultures and microscopy for ova and parasites)	13 (65)
Stain for cryptosporidium (AFB)	6 (30)
Microscopy for polymorphonuclear cells	6 (30)
Flexible sigmoidoscopy with biopsy	1 (5)
Flexible sigmoidoscopy without biopsy	1 (5)
Colonoscopy with biopsy	1 (5)
No description or workup mentioned	7 (35)

Table 4. *Etiology of diarrhea.*

	Number of Patients (%)
Candidiasis (2 on culture and 1 on biopsy stains)	3 (15)
Shigellosis	1 (5)
Mycobacterium avium intracellulare	1 (5)
Campylobacter jejuni	1 (5)
Clostridium difficile	1 (5)
Cytomegalovirus	1 (5)

when there is sudden deterioration of liver function and clinical status, and no obvious etiology can explain it.

Based on the results generated from the present study, we recommend that the initial workup for AIDS patients with digestive system complaints should be restricted because of the rising costs associated with testing every patient, and the frequent low yield of such tests. In addition, many of the opportunistic infections do not have an effective treatment modality, and pinpointing a specific etiology contributes little to patient management in many instances. Chronic diarrhea is a fairly common complaint among AIDS patients, however, and the initial evaluation certainly should include stool microscopy with acid-fast stain and Wright's stain, identification of ova and parasites with wet smears and special concentration, and three stool cultures. Further workup should be done if the clinical status of the patient suddenly changes. Those patients with bloody and/or purulent diarrhea should have flexible sigmoidoscopy with biopsy. If malabsorption is suggested clinically, a D-xylose test should be performed and small bowel biopsy obtained. Those with oral candidiasis who develop dysphagia and odynophagia, and nonresponders to antifungal therapy will require an endoscopic examination of the esophagus for diagnosis and treatment of esophagitis. ■

Drs. Gupta and Kawanishi are affiliated with the Division of Gastroenterology, Department of Medicine, UMDNJ-Robert Wood Johnson Medical School. The paper was submitted in June 1991 and accepted in September 1991. Address reprint requests to Dr. Kawanishi, UMDNJ-Robert Wood Johnson Medical School, CN 19, New Brunswick, NJ 08903-0019.

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Doctors Must Review Referral and Business Relationships

Sandra E.D. McGraw, JD, MBA
Nancy W. Miller, JD
Neil B. Caesar, JD

Ten safe harbors describe referral relationships and other business arrangements exempt from prosecution under federal anti-kickback law. As the statute's prohibitions are broad and the safe harbors narrow, physicians should review—carefully—their practice relationships.

Final Rules on Medicare fraud and abuse anti-kickback provisions have been published by the Office of the Inspector General (OIG) of the Department of Health and Human Services (HHS). These new rules establish "safe harbors" that provide exemption from prosecution under the anti-kickback statute.

The anti-kickback statute is extremely broad; it is intended to cover payments of any kind, offered or paid, to induce referrals of Medicare/Medicaid patients, or referrals of business for goods or services paid for by Medicare or Medicaid. The statute provides for both criminal and civil penalties. Since it is so broad, many harmless arrangements are technically covered and, therefore, subject to prosecution. The narrow exemptions called safe harbors specify the business relationships that will be exempt from prosecution. If an arrangement does not comply with the safe harbor requirements, it is not necessarily illegal. However, transactions within the safe harbor provisions are exempt from anti-kickback prosecution.

The safe harbor provisions address a variety of issues, including: investments, joint ventures, space and equipment rentals, management and personal service contracts, practice sales, fee discounts, referral services, warranties, group purchasing organizations, and waivers of deductibles/coinsurance.

These regulations are effective immediately. If a physician has any arrangements, joint ventures, or the like, to which the safe harbors apply, but he does not meet all of the criteria listed, the physician may wish to have his arrangements reviewed to determine any risks.

For a business arrangement to comply with one of the ten safe harbors, each detail of the particular safe harbor provision must be met. Where payments or arrangements involve more than one safe harbor, each payment and arrangement must be analyzed to determine if all details of each safe harbor are met. If a physician is part of a venture covered by the safe harbors, but he has chosen not to comply fully with one of the exemptions, or he does not meet each of the criteria, then he risks scrutiny and possible prosecution by OIG.

While this article addresses most of the proposed safe harbors in some detail, the three safe harbors dealing with referral services, warranties, and group purchasing organizations will not be discussed since the majority of physicians are not involved in these types of ventures.

REFERRAL INDUCEMENTS

Payments for or to induce referrals are illegal. However, many typical business transactions, that may appear legal, actually may violate the statute. For example, you are in a potentially abusive situation if you refer patients to a joint venture (perhaps an MRI venture, an AmSurg, or a diagnostic testing center) in which you are an investor, if you lease office space at above market rate from a referring physician, or if you lease office space at below market rental rate from a hospital. As previous case law has made clear, if even one of the purposes of the relationship is to induce referrals, then the kickback statute is violated. Case law also has held that the statute is violated if payments are not entirely attributable to the delivery of goods or services.

Increased costs to the Medicare or Medicaid programs and/or to patients are not the only criteria examined when determining if a particular business arrangement is abusive or fraudulent. The real violation is payment for the inducement of referrals.

Given the broad scope of the anti-kickback statute, and the nar-

row protections of these safe harbors, physicians should review their practice relationships carefully. The safe harbors are as follows:

1. Investment Interests. Payments made to an investor as a return on investment interest, such as a dividend or interest income, will be protected as long as the standards in this safe harbor are met.

Under this safe harbor, the term "investor" includes individuals and entities who own their interest directly or indirectly. For example, an interest in a joint venture held by a family member of a referring physician would be deemed held by the referring physician himself. Likewise, if an entity, such as a group practice or retirement plan trust in which the referring physician is an owner or participant, holds an interest in a joint venture, then ownership in the entity is deemed to be held by the referring physician.

This safe harbor targets not only investors who actually make referrals, but also those who have the ability to make or influence the referral stream—as well as investors doing business with the entity, e.g. suppliers. An investment interest includes both equity and debt investments, e.g. stocks, bonds, notes.

The regulations divide investment interests into two categories: investment in large publicly traded entities and investment in small entities, such as limited partnerships; each category has different requirements for safe harbor protection. Investment in large, publicly traded entities refers to dividend and interest payments made to referring investors from large publicly traded corporations where the investment interest was obtained at fair market value through trading on a securities exchange. For example, you may invest in large pharmaceutical companies, even though you prescribe their products. To be protected under this safe harbor, the entity must possess more than $50,000,000 in "undepreciated net tangible assets" (based on acquisition cost) within the previous fiscal year or prior 12-month period. This test is applied only to those assets related to the company's health care line of business, and excludes all intangible assets, such as goodwill. Additionally, the referring investor must not receive any preferential or different treatment than a nonreferrer. There are additional substantive requirements under this safe harbor, but these requirements do not pertain to the majority of physician investments.

Investment in small entities/joint ventures refers to joint venture payments to investors (limited and general partners, shareholders, and holders of debt). These investments are subject to a new "60-40 rule." No more than 40 percent of the investment interests may be held by investors who are in a position to make referrals, furnish items or services, or otherwise engage in business activity with the entity (collectively referred to as "referring investors"), and no more than 40 percent of the gross revenue may come from investor referrals.

Investors are classified as either active or passive. An active investor is one who either is responsible for the day-to-day management of the entity (such as a bona fide general partner), or agrees in writing to undertake liability for the actions of the entity's agents. A passive investor is one who is not active, such as a limited partner, shareholder, or holder of debt security.

To comply with the "60-40 rule," eight standards must be met:

1. Referring investors may hold no more than 40 percent of the value of each class of debt/equity.

2. Investment terms must be the same as for all passive investors, whether or not they are in a position to make or influence referrals.

3. Investment terms offered to referring investors must not be related to the volume of referrals, items, or services furnished, or the amount of business otherwise generated from that investor.

4. A passive investor may not be required to make referrals as a condition for remaining an investor.

5. The entity must not market or furnish its services differently to passive investors than it does to noninvestors.

6. No more than 40 percent of the gross revenue of the entity in the previous fiscal year or 12-month period may come from referrals or other business generated by investors.

7. The entity must not loan or guarantee funds for a referring investor if the investor uses any part of such a loan to obtain the investment interest.

8. The return on investment must be directly proportional to the investor's capital investment.

To satisfy this safe harbor, all investors—active and passive—must meet all eight standards. If one class of investors qualifies, but the other investors fail any one of these standards, then safe harbor protection will not be given to any investors in the entity.

This safe harbor provision becomes complicated in cases of ownership interests held indirectly through other entities. For example, assume physicians in a group are limited (passive) partners in entity "A," (a management company) which in turn is the active investor in entity "B" (an AmSurg, MRI, or diagnostic or other facility). For entity "B" (the facility) to qualify under this safe harbor, entity "A" (the management company) must meet all the requirements for active investors in entity "B" and each of the individual investors in entity "A" (each physician) must meet all the requirements as passive investors in entity "B."

If a physician is part of a joint venture, or if he provides services for a venture (such as a radiologist reading MRIs), then he must

meet these requirements and the venture must comply with these criteria. The physician must document compliance efforts. Also, note that while not specifically required, comments to the safe harbors raise the ethical duty for each physician to disclose his financial interest when referring a patient to such a venture.

2. Space Rental. Three separate safe harbors covering space leases, equipment rentals, and personal service and management contracts have virtually identical rules. If renting space to (or from) any health care provider in a position to make (or receive) referrals, five of the following criteria must be met: there must be a signed written rental agreement; the lease must specify the precise premises covered; if access to the premises is for periodic intervals of time (as opposed to full time), the lease must specify the exact schedule of the intervals, the length, and the rent for each interval; the term of the lease must be for at least one year; and total lease payments must be determined in advance and must be consistent with fair market value, not taking into account the volume or value of any referrals of business otherwise generated between the parties. Under this definition, rental charges may not reflect value tied to the proximity or convenience of potential sources of referrals.

We recommend that if a physician is renting space to (or from) any other health care provider who is not a member of the practice, that the physician meet all provisions of this safe harbor, and document, by way of an appraisal or otherwise, that the physician is paying a fair market lease rate. This is particularly important if the physician is in a part-time rental arrangement. If a physician is renting space or equipment with someone in a position to make or accept referrals, the physician will not receive safe harbor protection if rental payments are based on utilization.

3. Equipment Rental. A physician must meet the previous five criteria for an equipment rental arrangement to qualify for an exemption under these safe harbor rules. In this case, however, fair market value means the value of the equipment when obtained from the manufacturer/distributor, but not adjusted to reflect any additional value attributed to the equipment for proximity or convenience of sources of referral. Again, documentation on fair rental values and compliance efforts is critical.

4. Personal Service and Management Contracts. The first five criteria of this safe harbor are the same as for the space and equipment rental safe harbors (substituting the word "agreement" for "lease"). The sixth requirement, though, prohibits counseling or promoting a business arrangement or other activity that violates state or federal law (such as advice to develop an impermissible joint venture, or counseling the routine waiver of Medicare deductibles and copays). This section only protects contacts with agents. An agent is defined as any person other than a bona fide employee who has an agreement to perform management or personal services for or on behalf of the principal. An individual who does not meet the personal service and management contract provision still may meet the employment exemption discussed in the employer-employee section. When it comes to professional relationships, a physician should seek expert advice from a consultant or attorney skilled in medical practice relationships.

5. Practice Sales/Purchases. OIG believes that practice sales represents an area of significant abuse, and, thus, this exemption is extremely narrow. For this safe harbor to apply, the selling physician must be "out of the picture" within one year of signing the sales agreement. The safe harbor applies only if: the period from the date of the first agreement pertaining to the sale and the completion of the sale is not more than one year; and the selling practitioner is not in a professional position to make referrals to, or otherwise generate business for, the purchaser after the one-year period.

OIG has indicated that if these two conditions are met, the safe harbor will apply even if payments made by the buyer to the seller extend beyond the one-year period. Thus, when considering a practice purchase or sale, there is clear latitude on payment structure. Likewise, as you still have one year to wind down, you should have ample time to facilitate the patient transfer if you are organized in your approach to the sale.

6. Employer-Employee. This safe harbor protects payments made by an employer to a bona fide employee. This safe harbor adopted the IRS definition of employee, meaning that the employer controls the employee-physician's work, schedule of hours, and services. If the physician does not qualify as an employee, he is regarded as an independent contractor, and, therefore, payments to him do not qualify for employee safe harbor protection. (Payments to an independent contractor may be protected under the more stringent regulations applicable to personal service and management contracts.)

If a physician has an independent contractor physician (locum tenens) in his practice, consider whether he is an employee. If so, the physician should formally change his relationship from a Medicare and tax standpoint.

7. Discounts. If your practice routinely discounts its fees to any select payor, and some of those discounts are for services rendered to Medicare or state health care program beneficiaries, then you also should meet the discount criteria. Those criteria, as applicable only to physician's fees, are as follows:

The buyer must: discount the fee at the time of the original

service; report the discount on the claim; and as requested, submit additional fee and discount information.

The seller (physician) must: report the discount on the statement submitted by the buyer and inform the buyer of its obligation to report the discount; or if the value of the discount is not known at the time of service, then report the existence of the discount program and provide the buyer with a means of calculating the discount and the specific goods or services to which the discount applies.

Discounts mean mutually agreed price (fee) reductions, and might include rebates, credits, or flat fee or percentage reductions. Discounts do not, however, include: cash payments, furnishing free or lower-priced services in exchange for buying different goods, reductions applicable to a specific payor that excludes Medicare or state health plans, reductions to a beneficiary, i.e. waiver of copay, warranties, or services provided under personal service, or management contracts.

If a physician has agreed, for example, to discount fees to an area employer with Medicare beneficiaries, then the physician should itemize his normal fee, and then disclose the discount.

FUTURE SAFE HARBORS

Additional safe harbor regulations are being considered. These proposals include:

1. Cross-Referral Arrangements. This new safe harbor might protect cross-referral arrangements where no money is exchanged between the parties. This would include the traditional referral patterns between a primary care practitioner and a specialist, between a hospital and a nursing home, and among practitioners with a group practice where the patient then is referred back to the treating physician.

2. Wholly Owned Subsidiaries. This new regulation might provide additional protection for payments made between entities with common ownership by protecting payments between the entities (for example, a physician-practice and its wholly owned but separate diagnostic corporation or other practice). It would not cover wholly owned shell entities established for fraudulent purposes, to hide the identity of its owners, or to shield assets.

3. Additional Investment Safe Harbor. The current investment safe harbor does not include a provision covering business structures composed entirely of active investors. For these situations, the government is considering a new safe harbor. This possible new safe harbor would protect physician referrals of patients to an entity in which the physician has an ownership interest and where he actually performs the service for which the referral is made if the physician first saw that patient in his office, i.e. referrals from a physician's office to a diagnostic center in which he owns an interest and performs the test. This will likely be a narrow exception protecting only those payments with no likelihood of abuse.

4. Malpractice Insurance. Such a safe harbor might permit hospital subsidies of a physician's malpractice premiums.

5. Group Practice Sales. An additional safe harbor is being considered to expand the practice sales safe harbor to address purchases of group practices. While expected to be very limited, a new regulation in this area should prove helpful.

6. Physician Recruitment. Prior versions of the proposed safe harbors specifically protected certain hospital recruiting activities designed to attract new physicians to the hospital's communities. While this safe harbor was dropped from the final regulations, various comments indicate that the issue may be covered in future regulations.

7. HMOs, PPOs, and Other Managed Care Plans. HHS is considering protecting the practice of certain prepaid health plans e.g. HMOs, that have contracts or agreements with HCFA or a state agency, and offer beneficiaries increased benefits coverage, reduced coinsurance, deductibles or copayments, or reduced premiums where certain standards are met. This possible new safe harbor will cover a variety of arrangements designed to protect medical groups (and other health care providers) that furnish services to health plan beneficiaries at reduced prices. This future safe harbor will likely protect contracts between health plans and contract providers furnishing covered benefits. ■

Ms. McGraw, Ms. Miller, and Mr. Caesar are consultants with The Health Care Group. The article was submitted in August 1991 and accepted in September 1991. Requests for reprints may be addressed to Mr. Merrill S. Meadow, The Health Care Group, 140 West Germantown Pike, Suite 200, Plymouth Meeting, PA 19462.

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Change in Presentation of Breast Cancer in a Community Hospital

Fred M. Palace, MD
Jory G. Magidson, MD
Lawrence C. Swayne, MD

A retrospective analysis of breast cancer patients treated in a community hospital in 1980 and 1990 showed screening mammography successfully detected earlier stages of disease at presentation including a fivefold increase in patients with stage 0 disease.

Breast cancer is the most common and most feared malignancy in women in the United States. In 1991, it caused an estimated 44,800 deaths.[1] In general, patients with earlier stages of disease at the time of initial detection have experienced better survival rates.[2] Nevertheless, despite impressive advances in surgery, radiation therapy, and chemotherapy, the stage-to-stage comparative survival for patients with breast cancer has not changed significantly over the last 50 years.[3] Awareness of this data, therefore, prompted an effort to shift the breast cancer survival curve by detecting patients with earlier disease using screening mammography.

The Breast Cancer Detection Project was instituted by the American Cancer Society, the National Cancer Institute, and the American College of Radiology. This project documented the effectiveness of screening for the early diagnosis of breast cancer.[4] Subsequently, the American Cancer Society and the American College of Radiology generated guidelines for screening mammography[5,6] that were endorsed and promulgated by the National Cancer Institute, the American Medical Association, the American College of Surgeons, the American Academy of Family Physicians, and other national medical societies. Women's interest groups, in cooperation with the American Cancer Society, also publicized the concept of screening mammography.

The first mammographic examination at Morristown Memorial Hospital, a 687-bed community hospital, was performed in 1968 using industrial film. In 1972, the xerographic technique was used until 1985 when film screen mammography technicians began using dedicated mammographic equipment and low-dose techniques. The Breast Center of Morristown, a facility owned by the Physicians' Hospital Alliance composed of the for-profit subsidiary of Morristown Memorial Hospital and the Physicians' Association of Morris, opened in January 1986. In addition, mammography was performed in two private practice radiology offices in Morristown, using film screen techniques.

Radiologists at Morristown Memorial Hospital were active in continuing medical education efforts in the community, speaking at surgical and medical grand rounds and to the members of the Department of Obstetrics and Gynecology on several occasions.

Table. ***AJCC breast cancer stage grouping.***[7]

Stage 0	Tis*	N0	M0
Stage I	T1	N0	M0
Stage IIA	T0	N1	M0
	T1	N1	M0
	T2	N0	M0
Stage IIB	T2	N1	M0
	T3	N0	M0
Stage IIIA	T0	N2	M0
	T1	N2	M0
	T2	N2	M0
	T3	N1, N2	M0
Stage IIIB	T4	Any N	M0
	Any T	N3	M0
Stage IV	Any T	Any N	M1

*In situ

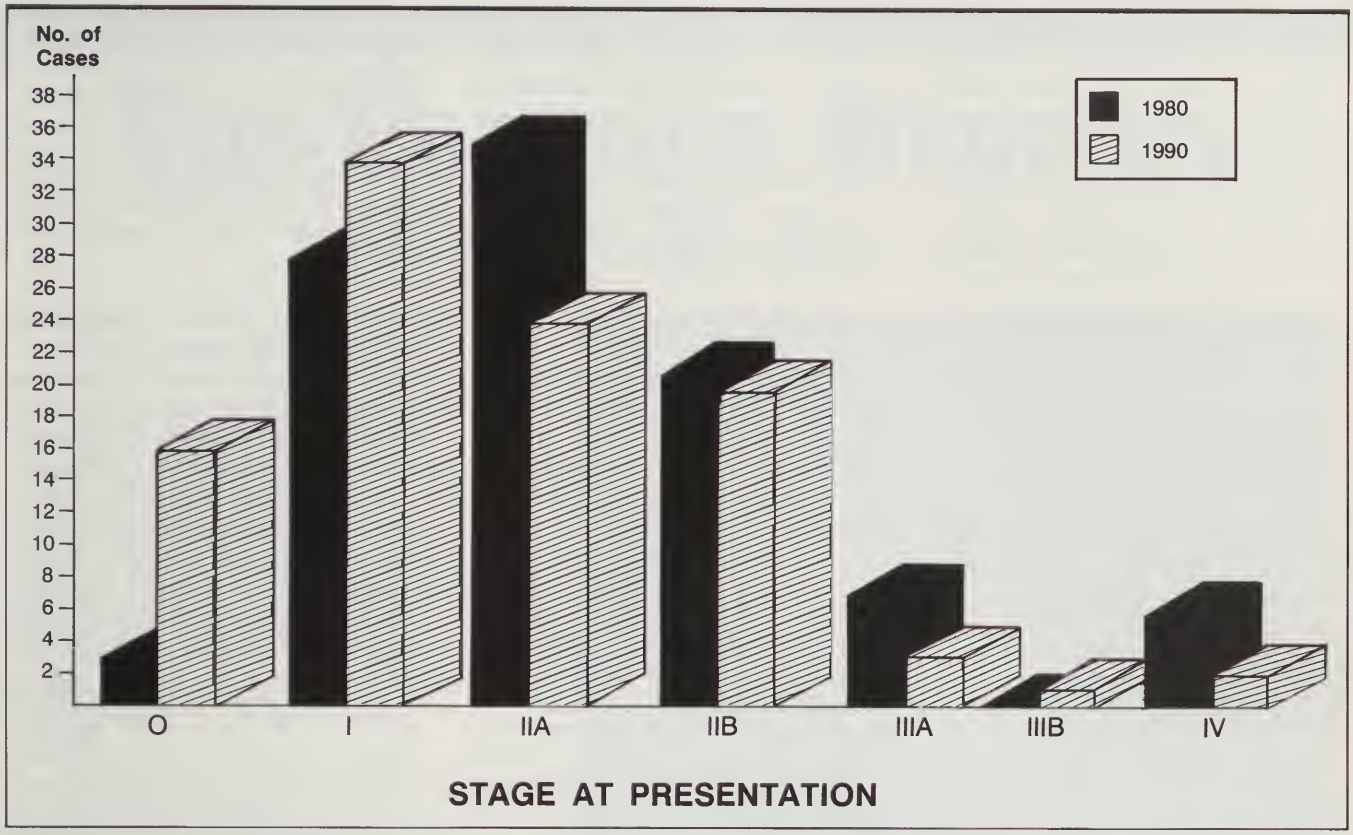


Figure. Graph of distributions by presenting stage of the first consecutive 100 patients with carcinoma of the breast at Morristown Memorial Hospital in 1980 and 1990.

As a result of these efforts, the campaign of the American Cancer Society, and the work of various other professional educational institutions (including the Academy of Medicine of New Jersey and the Medical Society of New Jersey), the number of mammograms interpreted at Morristown Memorial Hospital increased from 1 per month in 1969, to 4 to 5 per day in 1979, to over 60 per day in 1990. The purpose of this report is to assess the impact of mammographic screening by comparing the stage at presentation of breast cancer patients at Morristown Memorial Hospital in 1980 and 1990.

STAGING CRITERIA

All cases were TNM (tumor size, nodal status, metastatic condition) staged following surgery, based upon pathologic findings, using the American College of Radiology, College of American Pathologists, American College of Surgeons, American Cancer Society, National Cancer Institute, and American College of Physicians-sponsored American Joint Committee on Cancer (AJCC) classification schema for staging of breast carcinoma, as it appears in the third edition of *The Manual for Staging of Cancer* (Table).[7] In cases where surgical sampling of axillary lymph nodes did not occur, staging was based upon clinical findings. The 1980 cases, originally staged according to the second edition of *The Manual for Staging of Cancer*[8] were restaged for consistency according to the third edition.

RESULTS

The Figure depicts the distributions by stage of the first 100 patients with carcinoma of the breast at Morristown Memorial Hospital in 1980 and 1990. Comparison of the data from 1980 and 1990 reveals a fivefold increase of patients with stage 0, a slight increase of patients with Stage I disease, and a relative decline of patients with Stage IIA, Stage IIB, Stage IIIB, and Stage IV disease. A Pearson Chi-square analysis of the data shows a statistically significant difference ($P = 0.013$) in the distribution of stages at presentation between the 1980 and 1990 patient groups.

DISCUSSION

Breast cancer survival is correlated with lesion size and the status of the regional lymph nodes. Smaller lesions without histologic evidence of axillary metastases are known to have the best prognosis.[2] Multiple studies have shown that screening mammography can be more sensitive than manual palpation for breast cancer detection.[9,10] Nevertheless, only 10 percent of American women undergo screening mammography at present.[11] Explanations for underutilization include concerns about radiation, skepticism that early detection significantly will improve overall mortality rates, cost, and possible inconvenience.[12] The risk from radiation, however, is negligible at the low doses of modern mammographic techniques[13] and evidence is accumulating that mammographic screening may result

in both earlier detection[4] and improved survival.[10] A published analysis of data from five major screening studies indicated that annual screening of all women aged 40 and over by state-of-the-art mammography with two views per breast and physical examination could reduce breast cancer mortality by at least 40 percent and possibly as much as 50 percent.[10]

Since the most significant survival statistic for breast cancer mortality is at the 20-year mark, it will be some time before the data are available for the cohort of women who had breast cancer discovered in Morristown in 1990. Nevertheless, a reduction in mortality in our patients is expected. Of particular interest is the fivefold increase in Stage 0—in situ carcinomas that occurred in our study. This finding is not surprising, since screening mammography frequently can detect early cancers long before they are clinically palpable.[4]

SUMMARY

An aggressive mammographic screening program under the auspices of a community hospital resulted in a significantly earlier detection of breast cancer at presentation in 1990 as compared to 1980. It is anticipated that further followup will show a reduction in cancer mortality as a result of this earlier detection. ■

Drs. Palace and Swayne are affiliated with the Department of Radiology, Morristown Memorial Hospital and the Department of Radiology, College of Physicians and Surgeons, Columbia University, New York. Dr. Magidson is affiliated with the Department of Pathology, Morristown Memorial Hospital. The paper was submitted in August 1991 and accepted in October 1991. Address reprint requests to Dr. Palace, Morristown Memorial Hospital, 100 Madison Avenue, Morristown, NJ 07960.

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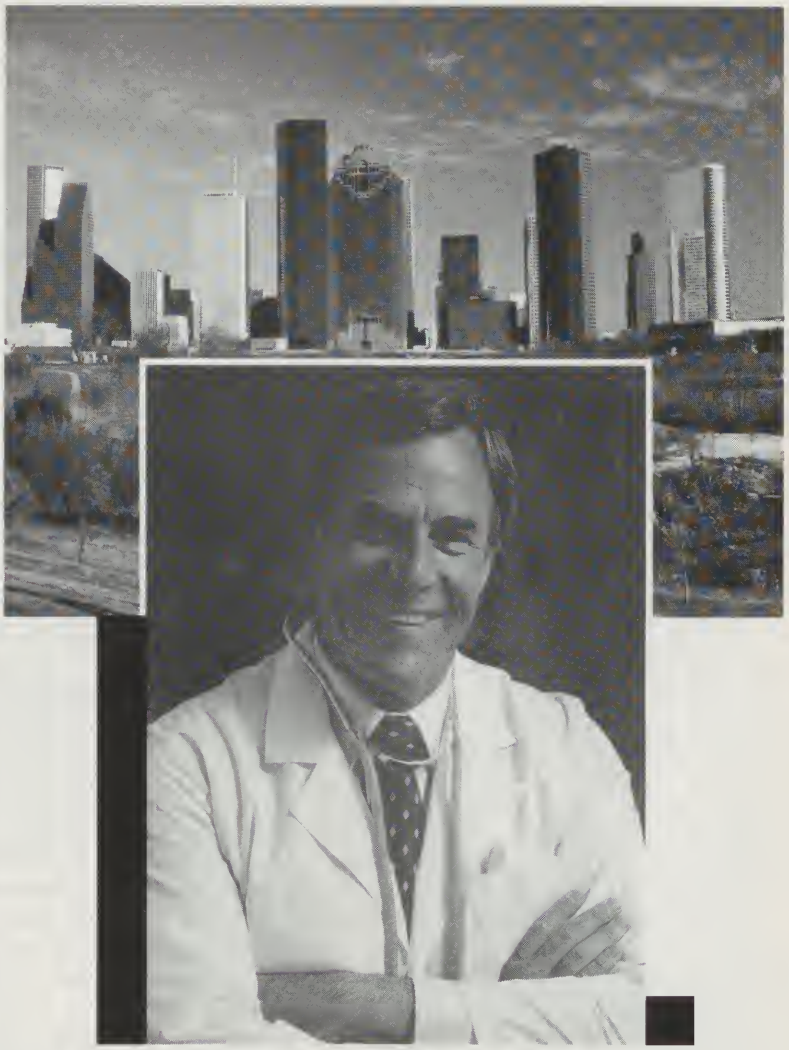
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Frank Vozos, MD

Somatostatin and its long-acting analog have a host of activities and potential applications in medicine today. Somatostatin is a naturally occurring peptide containing 14 amino acids. The following is one example of the many uses of somatostatin in the surgical patient.

Since its emergence in the surgical world, the applications for somatostatin have become increasingly varied. Somatostatin is a naturally occurring peptide containing 14 amino acids. It initially was discovered in sheep hypothalamus but it has been found in other areas of the brain, pancreatic islet D cells, gastric and intestinal epithelium, intestinal myenteric neurons, salivary gland, and parafollicular cells of the thyroid.[1]

Somatostatin has a host of activities, inhibitory in nature, that makes it applicable in treating various surgical disorders. Its property of inhibition of various endocrine secretions, e.g. gastrin, secretin, VIP, insulin, makes this a viable adjunct in the treatment of various endocrine tumors. Its hemodynamic effects of decreasing celiac and mesenteric blood flow as well as its concomitant cytoprotective effect of the stomach and its ability to suppress acid production, explain the varying success in treating hemorrhagic peptic ulcer disease.[1] The effects on the gastrointestinal tract of decreasing motility, inhibiting excretion of intestinal epithelial electrolytes and water, and decreasing pancreatic secretions, give credence to its use in treating both pancreatic and enterocutaneous fistulas.[1-6]

The disadvantages of somatostatin are its very short half-life necessitating continuous intravenous infusion and its ability to cause glucose intolerance.[6] These problems are overcome with the emergence of agents such as octreotide, a long-acting, more potent somatostatin analog.

Octreotide has a half-life of eight hours and can be administered via the subcutaneous route. It is safe, has little influence on glucose tolerance, and is well tolerated.[4,6]

Octreotide has been used clinically in the management of postoperative enterocutaneous fistulas, as an adjunct to the standard therapy of bowel rest and parenteral nutrition.[4,6,7] Nubiola reported a dramatic reduction in fistula output within 24 hours of administering octreotide (mean reduction of output of 55 percent). A spontaneous closure rate of 78 percent was obtained in a mean of 5.8 days.[6] This correlated with earlier work where fistula closure occurred in 4.5 days, with a range of 2 to 10 days.[4]

Although the spontaneous closure rate using octreotide is similar to studies that have used standard therapy, the time needed to achieve fistula closure is significantly shortened in those fistulas that are managed conservatively, making octreotide a desirable therapeutic option.[4,6,7]

CASE REPORT

A 41-year-old black female underwent a radical subtotal gastrectomy for a moderately well-differentiated adenocarcinoma of the distal stomach. The tumor involved lymph nodes of the lesser omentum, but the area of the duodenum was free from involvement. The duodenal stump was closed with a stapling device, without apparent difficulty. Following a successful hospital course and subsequent discharge, the patient was readmitted on postoperative day 13 with moderate drainage from a previous drain site. She had abdominal pain and tenderness, a fever of 103°C, and a leukocytosis of 19,000/mm^3. A computed tomograph (CT) scan failed to reveal an abscess and a subsequent fistulagram showed a duodenal-cutaneous fistula.

The patient was treated conservatively with bowel rest, total parenteral nutrition, antibiotics, and octreotide (0.1 mg by subcutaneous injection, every 6 hours). Within 48 hours, there was a distinct decrease in the diameter of the fistula tract as well as near total stoppage of fistula output. The patient was treated for nine days with octreotide

and discharged in satisfactory condition.

DISCUSSION

This is a case of a patient successfully managed with octreotide, a somatostatin analog, for postgastrectomy duodenal stump leak. Duodenal stump leak occurs at a rate of approximately 3 percent.[8] This varies depending upon the technique used, with stapled duodenal stumps having consistently less reported leaks than hand-sewn stumps.[9-12] Stump leak usually is evident by postoperative day five, and includes signs of localized sepsis, fever, pain, leukocytosis, and a possible mass in the right upper quadrant. This can progress to oliguria and sepsis, and shock, and carries a mortality rate of as high as 50 percent.[8] If a drain or draining tract is in place, the patient may be treated nonoperatively, including nasogastric suction, total parenteral nutrition, and antibiotics.

In this case, a somatostatin analog was added to the standard regimen of conservative treatment. Results were noticed within 48 hours, and the fistula closed completely within nine days, yielding a very abbreviated second hospital course. These findings correlate with the findings reported by Nubiola, where enterocutaneous fistula closure occurred in two to ten days using octreotide along with standard conservative management.[4,6]

It was interesting that the fistula was not diagnosed until postoperative day 13, and required a second admission to the hospital. Chassin reported a patient who was discharged, and on postoperative day 21, the patient developed a duodenal fistula occurring along the drain tract.[9] This demonstrates that duodenal stump leaks may not always be typical, and may occur much later than the expected postoperative day 5.

CONCLUSION

Our patient was managed successfully with octreotide in addition to standard conservative therapy for a duodenal stump leak. Although the patient may have been managed effectively without the addition of this compound, the somatostatin analog helped to reduce the fistula output, accelerating closure of the fistula, and reducing the period of parenteral nutrition and hospitalization, thereby improving the quality of life. With further investigation, the use of somatostatin analogs such as octreotide may become an integral part of the conservative management of duodenal stump leaks. ■

Drs. Zaccaria and Vozos are affiliated with the Department of Surgery, Monmouth Medical Center. The paper was submitted in April 1991 and accepted in June 1991. Address reprint requests to Dr. Vozos, Monmouth Medical Center, 300 Second Avenue, Long Branch, NJ 07740.

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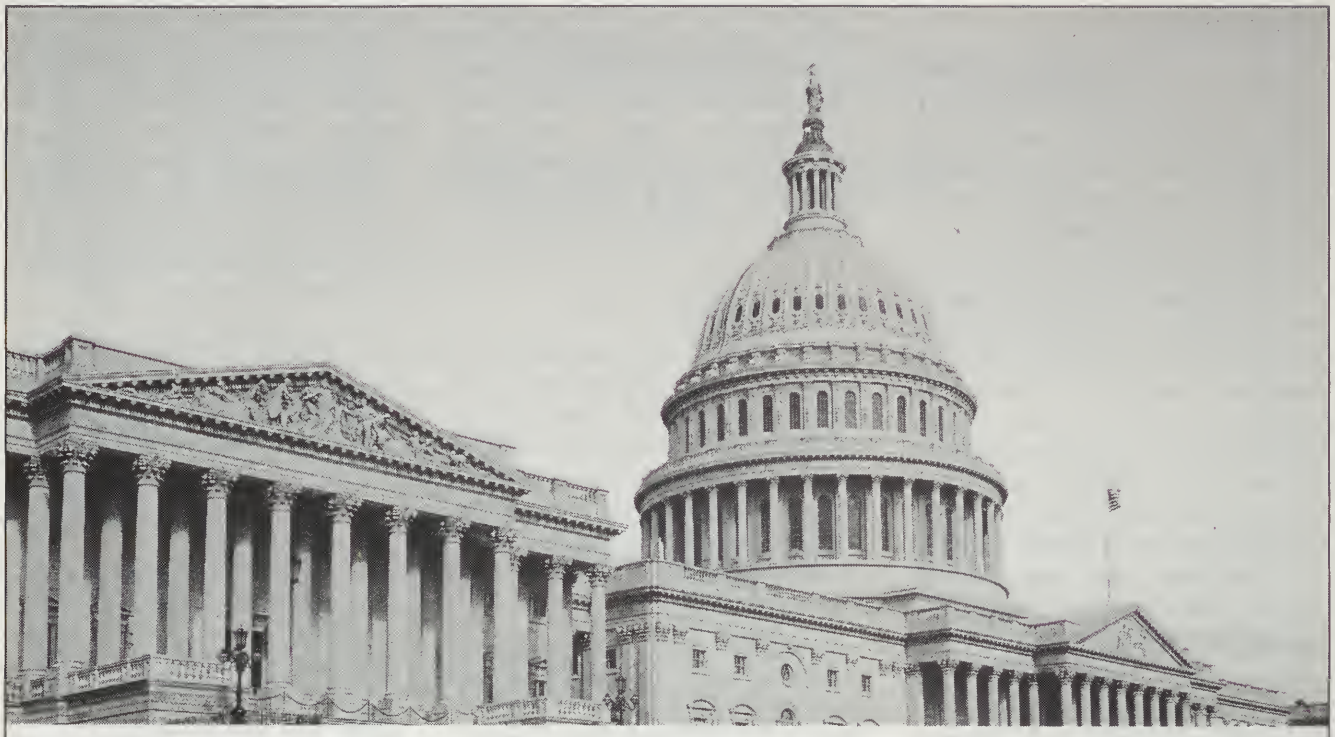
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Twelfth Century Thoughts from Maimonides

Morris Soled, MD

With the current interest in sports medicine, the writings of Moses ben Maimon, better known as Maimonides, a distinguished rabbi and physician, are quite interesting.

SENIOR CITIZENS

"Elderly people require that their bodies move, because the constitution of their bodies needs warmth. No elderly person should rest and repose without having done some exercise. On the other hand, he does not need strenuous exercise, because exertional athletics cools warmth that is weak, and extinguishes it."

Having knowledge of the Greek physicians before him, Maimonides in his treatise, *Regime of Health*, wrote, "Long before us, Hippocrates stated that the maintenance of health lies in forsaking the disinclination to exertion. Nothing is to be found that can substitute for exercise in any way, because in exercise the natural heat flames up and all the superfluities are expelled, while at rest the flame of the natural heat subsides and superfluities are engendered in the body, even though the food is of the very best quality and is moderate in quantity. And exercise will expel the harm done by most of the bad regimes that most men follow."[1]

WARM UP AND COOL DOWN

"It is proper to precede physical exercise by running and massaging the body. After this one exercises slowly and increases it until one reaches an optimum level of exercise. After the completion of the physical exercise one should rub the body with oil, and massage it moderately. . . ."[1]

EXERCISE HABIT

"Anyone who lives a sedentary life and does not exercise or he who postpones his excretions or he whose intestines are constipated, even if he eats good foods and takes care of himself according to proper principals—all his days will be painful ones and his strength will wane."

"The best time for exercise is at the beginning of the day, upon awakening from sleep, and after the expulsion of the superfluities. . . . The rule in this matter is that one should exert one's body and fatigue it every day in the morning until one's body begins to warm. Then one rests a little until one's soul has settled, and then one may eat. If one washes with warm water after the exercise, so much the better. After this, one should wait a little and then eat."

This information is contained in an article by Fred Rosner, MD, and Ira L. Weg, MD.[2] Our admiration grows for Maimonides's contribution when it is considered that he lived over 400 years before Dr. William Harvey described the circulation of the blood in his 1628 book, *Exercitatio Anatomica De Motu Cordis Et Sanguinis In Animalibus Cordis.*

In life as in death, Maimonides had no peers in his time. He was author of *The Oath of Maimonides.* On the religious side, he wrote, *A Guide of the Perplexed*, a philosophical and religious treatise still recognized today. He codified the 613 commandments which, to orthodox Jews, are part of the fabric of their daily lives. He declined an invitation from Richard the Lionhearted to be court physician in England. A traditional saying is that "From Moses to Moses, there was none like Moses." ■

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Dr. Soled is a member of the Committee on Publication, Medical Society of New Jersey. He is affiliated with Christ Hospital and Jewish Hospital and Rehabilitation Center, both in Jersey City.

Medical History: A History of Immunology

Morris H. Saffron, MD

Arthur M. Silverstein. New York, NY, Academic Press, Inc., 1991. No topic in medicine has aroused more interest during the past decade of the insidious AIDS epidemic than progress in immunology, the science through which we hopefully may look forward to eventual relief. We, therefore, welcome the present volume that is the first major work on the history of the subject to appear in English.

The author leads us back in time to the plague of Athens (430 B.C.), described so vividly by the historian Thucidides who made the significant observation that the individual who survived, henceforth, became immune to further attacks. Although the cause of this epidemic never has been determined, we are on more certain ground with the bubonic plague that devastated the Byzantine empire of Justinian (541 A.D.) and was to reappear periodically, culminating in the Black Death (1347).

One early Arabic observer, Rhazes (880-932), also noted the immunity conferred on an individual who recovered from an attack of smallpox. However, it is the Italian poet, Fracastora (1479-1553), who can plausibly be considered the true precursor of immunology. In his, "De Gontagione," Fracastora postulated the presence of invisible bodies transmitted from person to person during epidemics such as smallpox and he stressed the concept of acquired immunity.

It was not until the early 18th century that the first pivotal advance was made in the method of producing acquired immunity. Variolation, or the process of transmitting a mild form of smallpox from a recovering individual had the disadvantage of a moderate mortality risk, but was nonetheless widely adopted in Europe and America; at the end of the century it was superseded by Edward Jenner's discovery of the cowpox vaccination.

Dr. Silverstein then discusses the revolutionary 19th century and the age of bacteriology. He stated dogmatically, "Immunology was born of the dramatic success of Louis Pasteur's germ theory of disease with the significant assistance of Robert Koch." Having discovered the causes of specific diseases such as cholera and anthrax, the next step was to find a method of conferring immunity by preparing a vaccine made from attenuated bacterial products. All this was followed in rapid succession by a remarkable series of advances: Metchnikoff's phagocytes theory of immunity; Ehrlich's side-chain theory of antibody formation; the isolation of diphtheria toxin by Roux and Yersin; and the preparation of antitoxins against diphtheria and tetanus by von Behring and Kitisato.

Days of elation engendered by these early successes led to hopes that all bacterial diseases could be controlled by similar methods of antitoxin or vaccine therapy, but this vision soon was dispelled as tuberculosis, yellow fever, and other viral diseases remained utterly resistant. In the first decade of the 20th century, the euphoria had not utterly vanished and such important developments as Landsteiner's blood group, the theory of anaphylaxis, the Wassermann test for syphilis, and von Pirquet's theory of serum sickness should be noted.

World War I put a damper on research in this field and the next few decades were characterized by Dr. Silverstein, somewhat pessimistically, as the dark age of immunology. In the 1930s and 1940s, the discovery of sulfonamide, penicillin, and other antibiotics did indeed take center stage away from immunology. The renaissance occurred in the decade following World War II, when science proved itself vital in many newly developing disciplines including molecular biology. The new era of transplant surgery also was made possible by the study of immunogenetics.

From a historian's viewpoint, the various appendices that complete the book will prove very useful: a calendar of immunological progress, seminal discoveries, a bibliography, a list of Nobel prize winners, and a biographical dictionary with life sketches of almost 200 workers in the field.

Finally, aside from an overly enthusiastic tendency to redundancy and repetition, this book is highly recommended as a landmark effort to throw light on a difficult and ever-advancing field of knowledge. ■

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DOCTORS' NOTEBOOK

TRUSTEES' MINUTES

A regular meeting of the MSNJ Board of Trustees was held on December 15, 1991. Detailed minutes are on file with the secretary of your county society. A summary of significant actions follows:

President's Report.

Noted the following items: appreciation of the work of the MSNJ Task Force on AIDS; president's appointment to the Governor's Task Force on AIDS; Pennsylvania Blue Shield seminars on RBRVS system of reimbursement; *NEW JERSEY MEDICINE* will be sent to New Jersey legislators; importance of having another person present during a patient examination.

AMA Interim Meeting.

Heard from Karl T. Franzoni, MD, on the activities of the AMA Delegation: Joseph N. Micale, MD, Henry J. Mineur, MD, and Robert H. Stackpole, MD, were members of AMA reference committees; AMA information on RBRVS was distributed and will be published in this month's issue of *NEW JERSEY MEDICINE;* one-month grace period announced by the Health Care Financing Administration to allow physicians additional time to become acquainted with the new CPT-4 codes; copies of the 1992 CPT code book can be obtained from the AMA (1/800/621-8335); physicians who experience problems with RBRVS should notify the AMA Board of Trustees; and MSNJ will investigate the possibility of increasing the Medicare RBRVS reimbursement rates in Regions II and III.

Specialty Reports.

Received reports from Stanley S. Bergen, Jr, MD, president of the University of Medicine and Dentistry; Louis P. Scibetta, president of the New Jersey Hospital Association; Fred M. Palace, MD, liaison to the State Board of Medical Examiners; and the Academy of Medicine of New Jersey.

Executive Director's Report.

1. MSNJ Membership. Noted that there has been a modest increase in membership over a year ago.

2. MSNJ Financial Statements. Reviewed and approved MSNJ financial statements for the period ending November 30, 1991. Also, empowered the Executive Committee to review the pertinent facts and make a determination on the expenditure of an additional $130,000 by the Council on Public Relations for external media projects.

3. AMA Report on RBRVS Final Rule. Received the AMA report, "HCFA Release of the RBRVS Final Rule," for distribution.

4. Legislation. Discussed the following items: A-4367 (Medicare Acceptance)—amended in committee to include the PAAD income limits and released from committee; S-3539 (Optometric Drug)—scheduled for a floor vote and would authorize optometrists to diagnose disease and prescribe drugs; S-3510 (Physician Assistants)—passed in the Senate and an Assembly vote is expected in early January; and S-3491 (Nurse Practitioners)—a meeting is scheduled by the Assembly Health and Human Services Committee to consider this bill after nurses have agreed to the concept of working under physician supervision with protocols written by the State Board of Medical Examiners.

5. Blue Cross/Blue Shield. Concurred with the action taken by the Executive Committee, which was authorized to act on behalf of the Board and approved the recommendation of the Committee on Membership Services to remain with Donald F. Smith, to include preadmission certification, to transfer $470,000 out of the 1991 surplus, and to hold the rate level at the January 1, 1992, renewal.

6. Lawsuit by Lois Copeland, MD. Noted that Kent Masterson Brown, attorney representing the American Association of Physicians and Surgeons, expects to file litigation in federal district court on behalf of Dr. Copeland and a number of her patients on the issue of extracontractual rights by Medicare Part B subscribers; Mr. Maressa has agreed to review the documents.

MSNJ Auxiliary.

Received a report from the Auxiliary noting that the Auxiliary will participate in Campaign '92—that will elect a president, 35 senators, 435 assemblymen, 12 governors, and more than 1,000 state and local officials; and the annual trip to Washington, DC, scheduled April 1 to 2, 1992.

Council on Public Relations.

Approved the following recommendation:

That 30-year or more members of the Medical Society of New Jersey be recognized with presentation of either a plaque or pin—presented at the county level. It also is recommended that their names be published in *NEW JERSEY MEDICINE.*

Committee on Cancer Control.

Referred the following recom-

mendation back to the Committee for further study and rewording:

That MSNJ support legislative and regulatory initiatives to require health insurance companies, Medicaid, and Medicare, to provide reimbursement for "off label" use of approved drugs, provided that such drugs have been recognized for treatment of the specific diseases in established medical reference compendia.

Also, approved the following two recommendations:

That MSNJ support cancer screening procedures for high-risk patients and for other diseases in which screening has been demonstrated to be effective as a disease control measure.

That MSNJ support the involvement of New Jersey physicians in the National Surgical Adjuvant Breast Project (NSABP) for breast cancer prevention study with tamoxifen.

MSNJ AUXILIARY

Campaign '92 is underway and the Auxiliary is encouraging physicians and their spouses to become actively involved in what may prove to be the most important election of the century. On November 3, 1992, American citizens will have the right to vote for a president, 35 United States senators, 435 congressmen, 12 governors, and thousands of state and local officials. Many Auxiliary members already have joined the AMA in its "Participation '92"—a nationwide effort to interest medical families in the national, state, and local political campaigns and to urge its members to attend Republican and Democratic conventions as delegates or alternates. Hopefully, members of the entire medical community will use the opportunity to make their voices heard!

UMDNJ NOTES

UMDNJ adopts new policy. To ensure a safe environment for patients, employees, and students, UMDNJ has adopted a comprehensive policy on hepatitis B (HBV) and human immunodeficiency virus (HIV), the cause of AIDS. Addressing both HBV and HIV, the policy calls for each of UMDNJ's six schools, UMDNJ-University Hospital, and UMDNJ-Community Mental Health Centers to develop specific procedures to implement the policy. Six broad issues are covered: nondiscrimination, patient care, educational programs, research, work and learning environment, and compliance with laws. UMDNJ's new policy on HBV and HIV conforms closely to the newly proposed revision of the guidelines from the Centers for Disease Control (CDC) for preventing HIV transmission to patients.

Microwave facility for medical waste disposal. UMDNJ will use advanced microwave technology for the safe and cost-effective disposal of regulated medical waste on the Newark campus. Microwave disposal eliminates the need for smokestack and pollution-control equipment because there are no harmful air emissions and no liquid or chemical discharges. It also eliminates costly transportation of untreated infectious waste on city and state roadways to out-of-state incinerators. The processed matter becomes disinfected, no longer has the characteristics or risks of infectious waste, and is classified as municipal solid waste with bacteria levels less than ordinary household waste. The microwave unit will be housed in a completely enclosed steel container that has met rigorous performance requirements elsewhere in the United States and abroad. Completion is anticipated by the third quarter of 1993.

Physicians use video camera to diagnose cancer. Cancer specialists at UMDNJ are using a unique high-resolution video camera to diagnose moles for skin cancer, replacing biopsies. The camera was developed at UMDNJ-Robert Wood Johnson Medical School in conjunction with the Biomedical Engineering Department of Rutgers University. It is the only one of its kind in the United States. About twice the size of a video camcorder, it can detect skin cancer by tracking

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and checking changes in the size and color of moles over a period of several months. The camera currently is being used by oncologists and surgeons at the Melanoma-Pigmented Lesion Center, operated by UMDNJ-Robert Wood Johnson Medical School. It was developed by Dr. Dennis Devereux, professor of surgery and chief of surgical oncology at the medical school. The video camera is connected to a computer program that can identify 32,000 different shades and colors found in moles. The camera also can detect even the slightest exterior growth, another sign of malignancy.

Dr. Black honored by neuroscience publication. Dr. Ira Black, a pioneer in brain research, has been honored by a prestigious international publication for his contributions to the field of neuroscience. The editorial board of the *International Journal of Developmental Neuroscience* has presented Dr. Black with the first Viktor Hamburger Award for opening new vistas in developmental neuroscience. Dr. Hamburger is one of the fathers of neuroembryology. ☐ Stanley S. Bergen, Jr, MD

PLACEMENT FILE

The following physicians are seeking information on opportunities for practice in New Jersey. If you are interested in any further information concerning these physicians, please make inquiries directly to them.

Cardiology

Alan E. Kravitz, MD, 26900 Cedar Rd., #304, Beachwood, OH 44122. Jefferson 1969. Also, internal medicine. Board certified. Also, board certified (IM). Group or partnership. Available.

Endocrinology

Muriel Levy-Kern, MD, 90 Fleet Pl., Mineola, NY 11501. Universite Pierre et Marie Curie Faculte De Medicine (Paris) 1985. Board eligible. Group practice. Available June 1992.

Internal Medicine

Thomas F. De Blasio, MD, 100 Franklin St., Apt. 8B8, Morristown, NJ 07960. St. George's 1985. Board eligible. Solo or partnership. Available July 1992.

Cynthia K. Menack, MD, 3132 Perry Ave., Apt. 2A, Bronx, NY 10467. Mount Sinai 1989. Board eligible. Group practice or medical clinic. Available July 1992.

John Musico, MD, 262 Pine Valley Rd., Dover, DE 19901. St. George 1988. Board eligible. July 1992.

Pathology

Sarita Khanijo, MD, 1710 NW Calkins, Roseburg, OR 97470. MGM Medical College (India) 1976. Board certified. Group or partnership. Available.

Pediatrics

Sheryl S. Hertel, MD, 6205 Brogan Pl., St. Louis, MO 63128. St. Louis 1986. Also, internal medicine. Board eligible. Board certified (IM). Group. Available.

Pulmonary Medicine

Vinod Khanijo, MD, 1710 NW Calkins, Roseburg, OR 97470. Delhi University (India) 1963. Also, critical care. Board certified. Solo. Available July 1992.

Surgery

Victoria Lee, MD, 459 South St., #204, Fitchburg, MA 01420. Howard 1981. Board certified. Group, HMO, partnership. Available.

David M. Lemonick, MD, 957 North 6 St., New Hyde Park, NY 11040. NY Medical College 1981. Also, cardiothoracic and vascular surgery. Board certified. Also, board eligible (CARDIO-THOR). Private group. Available July 1992. ☐

1992 MSNJ Annual Meeting Proposed Daily Schedule

Saturday, May 2, 1992

3:30 p.m. Board of Trustees' Meeting

Sunday, May 3, 1992

8:00 a.m. Registration Opens
9:30 a.m. Message Center Opens
10:00 a.m. Educational Program
11:30 a.m. Exhibits Open
2:00 p.m. House of Delegates
3:30 p.m. Reference Committee Meetings

Monday, May 4, 1992

8:00 a.m. Registration Opens
8:00 a.m. Message Center Opens
8:30 a.m. Exhibits Open
9:00 a.m. House of Delegates (Election)
12:00 noon Golden Merit Award Ceremony and Reception
2:30 p.m. Reference Committee Meetings
5:00 p.m. JEMPAC Political Forum
5:45 p.m. JEMPAC Wine and Cheese Reception
6:30 p.m. Camden County Medical Society Reception

Tuesday, May 5, 1992

8:00 a.m. Registration Opens
8:00 a.m. Message Center Opens
8:30 a.m. Exhibits Open
9:00 a.m. House of Delegates
1:30 p.m. House of Delegates
2:00 p.m. Exhibits Close
7:00 p.m. Inaugural Reception and Dinner

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Wednesday, March 4, 1992

Office Management of Cardiac Arrhythmias

Moderator: Leonard N. Horowitz, M.D.

3:00-3:30 Diagnosis and management of atrial arrhythmias—
Charles D. Gottlieb, M.D.

3:30-4:00 Diagnosis and management of ventricular arrhythmias—
Leonard N. Horowitz, M.D.

4:00-5:00 Case Presentations—***Mark Preminger, M.D.***
Panel Discussion—***Steven J. Nierenberg, M.D., Howard Rosner, D.O., Gary J. Vigilante, M.D.***

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CONTINUING EDUCATION

ANESTHESIOLOGY

March

4 **Nonoperative Management of Chronic Back Pain**
10:30-11:30 A.M.—St. Mary's Hospital, Passaic
(AMNJ)

20-22 **33rd Annual NJ Postgraduate Anesthesia Seminar**
Hyatt Cherry Hill, Cherry Hill
(AMNJ)

DERMATOLOGY

March

4 **Dermatology Grand Rounds**

11 6-9 P.M.—Rutgers Community
18 Health Plan, U.S. Highway #1,
25 New Brunswick
(UMDNJ)

10 **Monthly Meeting**
7 P.M.—Schering Corporation, Kenilworth
(Dermatological Society of New Jersey and AMNJ)

18 **Dermatological Conference**
6-9 P.M.—Rutgers Community Health Plan, U.S. Highway #1, New Brunswick
(UMDNJ)

April

1 **Dermatology Grand Rounds**

8 6-9 P.M.—Rutgers Community
15 Health Plan, U.S. Highway #1,
22 New Brunswick
29 *(UMDNJ)*

14 **Monthly Meeting**
7 P.M.—Schering Corporation, Kenilworth
(Dermatological Society of New Jersey and AMNJ)

INFECTIOUS DISEASE

March

4 **Identification and Management of Asymptomatic HIV Infection**
11:30 A.M-12:30 P.M.—Rahway Hospital, Rahway
(AMNJ and NJDOH)

4 **Psychiatric Aspects of AIDS**
2:30-3:30 P.M.—Ancora Psychiatric Hospital, Hammonton
(AMNJ and NJDOH)

6 **Inter-Jersey Infectious**
13 **Disease Rounds**
20 Hackensack Medical Center,
27 Newark Beth Israel Medical Center, Saint Joseph's Hospital and Medical Center, Overlook Hospital, and University Hospital
(UMDNJ and AMNJ)

6 **AIDS Training and Resource Program for Hospital Health Educators**
12 Noon-1 P.M.—South Jersey Hospital System, Bridgeton
(AMNJ and NJDOH)

11 **AIDS Training and Resource Program for Hospital Health Educators**
9-10 A.M.—Elizabeth General Medical Center, Elizabeth
(AMNJ and NJDOH)

11 **Infection Control in the HIV Era**
9-10 A.M.—Elizabeth General Medical Center, Elizabeth
(AMNJ)

11 **Infection Control in the HIV Era**
11:30 A.M.-12:30 P.M.—Hamilton Hospital, Hamilton
(AMNJ)

25 **Diagnosis and Treatment of AIDS**
10-11 A.M.—Hunterdon Developmental Center, Clinton
(AMNJ and NJDOH)

April

3 **Inter-Jersey Infectious**
10 **Disease Rounds**
17 Hackensack Medical Center,
24 Newark Beth Israel Medical Center, Saint Joseph's Hospital and Medical Center, Overlook Hospital, and University Hospital
(UMDNJ and AMNJ)

8 **Findings of the Perinatal AIDS Project**
12:15-1:30 P.M.—Health and Agricultural Building, Trenton
(AMNJ and NJDOH)

14 **Diagnosis and Treatment of AIDS**
11 A.M.-12 Noon—West Jersey Health System, Voorhees
(AMNJ and NJDOH)

17 **Identification and Management of Asymptomatic HIV Infection**
11 A.M.-12 Noon—Chilton Memorial Hospital, Pompton Plains
(AMNJ and NJDOH)

29 **Identification and Management of Asymptomatic HIV Infection**
12 Noon-1 P.M.—South Jersey Hospital System, Bridgeton
(AMNJ and NJDOH)

MEDICINE

March

4 **Endocrinology Monthly Meeting**
6-9 P.M.—Holiday Inn, Newark Airport, Newark
(AMNJ)

4 **Endocrinology Grand Rounds**
11 11:30 A.M.-1 P.M.—VA Medical
18 Center, East Orange
25 *(AMNJ)*

4 **Interhospital Endocrine**
11 **Rounds**
18 3:30-5:30 P.M.—Newark Beth
25 Israel Medical Center, University Hospital, VA Medical Center, and United Hospitals Medical Center
(AMNJ)

Hahnemann University

Department of Medicine Grand Rounds
Wednesdays 8:30 a.m.-9:30 a.m.

February-April 1992

FEBRUARY 1992

February 5, 1992
PREVENTION OF RENAL FAILURE IN THE GERIATRIC PATIENT
Michael F. Michalis, M.D.
Professor of Clinical Medicine
New York Medical College
Director, Division of Nephrology
Lenox Hill Hospital

February 12, 1992
GENITAL HERPES
Lawrence Corey, M.D.
Professor of Laboratory Medicine, Microbiology and Medicine
Head, Virology Division
University of Washington
Seattle, WA

February 19, 1992
CUTANEOUS MANIFESTATIONS OF SYSTEMIC DISEASE
Cherie M. Ditre, M.D.
Assistant Professor of Medicine
Division of Dermatology
Hahnemann University

February 26, 1992
CARDIOVASCULAR DISORDERS AND ATHEROSCLEROSIS IN POST-MENOPAUSAL WOMEN
Jay Michael Sullivan, M.D.
Professor of Medicine
Chief, Division of Cardiovascular Diseases
University of Tennessee College of Medicine
Memphis, TN

MARCH 1992

March 4, 1992
CLINICAL PATHOLOGICAL CONFERENCE: VIOLANCEOUS MACULAR RASH, HEPATOMEGALY, FEVER & NEUROLOGIC ABNORMALITIES
Edward Dimitry, M.D.
Chief Resident, Department of Medicine
Hahnemann University
Cathy Jensen, M.D.
Chief Resident, Department of Medicine
Hahnemann University
Richard Maniglia, M.D.
Chief Resident, Department of Medicine
Hahnemann University
Jay Patel, M.D.
Chief Resident, Department of Medicine
Hahnemann University

March 11, 1992
CARDIOLOGY—ISSUES AND ANSWERS FOR THE 90's
Sylvan L. Weinberg, M.D.
Clinical Professor of Medicine
Wright State University
Dayton, OH

March 18, 1992
OCULAR MANIFESTATIONS OF AUTOIMMUNE DISEASE
Stephen Sinclair, M.D.
Professor of Ophthalmology
Vice Chairman, Department of Ophthalmology
Hahnemann University

March 25, 1992
HYPERTENSIVE NEPHROSCLEROSIS: IS IT BENIGN?
Jerome Porush, M.D.
Professor of Medicine
SUNY Health Science Center
Chief, Nephrology and Hypertension
Brookdale Hospital and Medical Center
Brooklyn, NY

APRIL 1992

April 1, 1992
CURRENT CONTRACEPTIVE MANAGEMENT: BENEFITS AND RISKS
Richard A. Baker, M.D.
Professor and Vice Chairman
Department of Obstetrics and Gynecology
Hahnemann University

April 8, 1992
PRINCIPLES GOVERNING THE USE OF THROMBOLYTIC AGENTS
Burton E. Sobel, M.D.
Lewin Professor of Medicine
Director, Cardiovascular Division
Washington University School of Medicine
St. Louis, MO

April 15, 1992
INTRAVASCULAR CATHETER-RELATED INFECTIONS
Dennis G. Macki, M.D.
Professor of Medicine
Chief, Section of Infectious Diseases
University of Wisconsin Medical School
Madison, WI

April 22, 1992
NUTRITIONAL SUPPORT IN THE CRITICAL CARE UNIT
Rosemarie L. Fisher, M.D.
Associate Professor of Medicine
Division of Digestive Diseases
Department of Internal Medicine
Yale University School of Medicine
New Haven, CT

ENDOSCOPIC MANAGEMENT OF BILIARY TRACT DISORDERS
Jerome H. Siegel, M.D.
Associate Professor of Medicine
Mt. Sinai School of Medicine
Chief, Endoscopy Unit
Beth Israel Medical Center North
New York, NY

April 29, 1992
DEVELOPMENT OF SKIN SUBSTITUTES
Richard L. Spielvogel, M.D.
Professor of Medicine and Dermatology
Director, Division of Dermatology
Hahnemann University

Hahnemann University Department of Medicine
Wednesday Medical Seminar Series
8:30 a.m.-3:30 p.m.

February 11, 1992
DIAGNOSIS AND TREATMENT OF SEXUALLY TRANSMITTED DISEASES

March 24-25, 1992
ADVANCES IN KIDNEY DISEASE

April 22, 1992
UPDATE IN GASTROENTEROLOGY, NUTRITION, AND ENDOSCOPY

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4 **Intensive Review of Internal**
11 **Medicine**
18 4-7 P.M.—University Hospital,
25 Medical Education Bldg., New Brunswick
(UMDNJ and AMNJ)

4 **Diabetic Retinopathy**
10:30-11:30 A.M.—Christ Hospital, Jersey City
(AMNJ)

6 **Diabetes-Related Cardiovascular Disease**
10:30-11:30 A.M.—Chilton Memorial Hospital, Pompton Plains
(AMNJ)

9 **Annual Review Course in Physical Medicine**
8 A.M.-5 P.M.—Kessler Institute, West Orange
(Kessler Institute)

9 **Proper Use of Endoscopy**
11:30 A.M.-1 P.M.—East Orange General Hospital, East Orange
(AMNJ)

11 **New Advance Directives Laws**
5:30-10 P.M.—Sheraton Meadowlands Hotel, Secaucus
(AMNJ)

11 **Hearing Loss: Prevention or Treatment**
10:30-11:30 A.M.—St. Mary's Hospital, Passaic

14 **Resident Presentations**
9 A.M.—Kessler Institute, West Orange
(Kessler Institute)

14- **Diagnosis and Management of**
15 **Musculoskeletal Disorders: State of the Art 1992**
8 A.M-5 P.M.—Kessler Institute, West Orange
(Kessler Institute)

16 **Diabetes-Related Cardiovascular Disease**
1-2 P.M.—New Lisbon Developmental Center, New Lisbon
(AMNJ)

18 **Diabetes-Related Cardiovascular Disease**
2:30-3:30 P.M.—Ancora Psychiatric Hospital, Hammonton
(AMNJ)

18 **Hematology and Ferrokinetics**
10:30-11:30 A.M.—St. Mary's Hospital, Passaic
(AMNJ)

19 **Highly Resistent Borderline and Narcissistic Cases**
1:30-2:30 P.M.—Essex County Hospital Center, Cedar Grove
(AMNJ)

20 **Occupational Safety and Health Administration Guidelines**
8:30 A.M.-2 P.M.—Medical Society of New Jersey, Lawrenceville
(AMNJ)

21 **Clinical Mammography**
8 A.M.-3:45 P.M.—Hyatt Regency, New Brunswick
(AMNJ)

25 **Diabetes-Related Cardiovascular Disease**
2:30-3:30 P.M.—Trenton Psychiatric Hospital, Trenton
(AMNJ)

25 **Chronic Pain Management and Issues Related to Iatrogenic Addiction**
10:30-11:30 A.M.—Christ Hospital, Jersey City
(AMNJ)

25- **Annual Meeting and Scientific**
29 **Assembly**
Caesars, Atlantic City
(NJ Academy of Family Physicians and AMNJ)

April

1 **Endocrinology Monthly Meeting**
6-9 P.M.—Holiday Inn, Newark Airport, Newark
(AMNJ)

1 **Endocrinology Grand Rounds**
8 11:30 A.M.-1 P.M.—VA Medical
15 Center, East Orange
22 *(AMNJ)*
29

1 **Interhospital Endocrine**
8 **Rounds**
15 3:30-5:30 P.M.—Newark Beth
22 Israel Medical Center,
29 University Hospital, VA Medical Center, and United Hospitals Medical Center
(AMNJ)

1 **Intensive Review of**
8 **Internal Medicine**
15 4-7 P.M.—University Hospital,
22 Medical Education Bldg.,
29 New Brunswick
(UMDNJ and AMNJ)

1 **Malpractice Insurance Crisis**
10:30-11:30 A.M.—Christ Hospital, Jersey City
(AMNJ)

7- **Annual Spring Meeting**
12 9 A.M-1 P.M.—Grand Cayman Islands
(NJ Orthopaedic Society)

13 **Diabetic Retinopathy**
1-2 P.M.—New Lisbon Developmental Center, New Lisbon
(AMNJ and NJDOH)

15 **Diabetes-Related Cardiovascular Disease**
10:30-11:30 A.M.—St. Mary's Hospital, Passaic
(AMNJ and NJDOH)

15 **Nutritional Assessment**
10-11 A.M.—Hunterdon Developmental Center, Clinton
(AMNJ)

22 **Annual Spring Conference: Association for Hospital Medical Education**
All day—MSNJ Headquarters, Lawrenceville
(Assoc. for Hospital Medical Education and AMNJ)

24 **Current Concepts in Neonatal Hematology**
8 A.M.-5 P.M.—Hyatt Regency, New Brunswick
(AMNJ and The Valerie Fund)

24 **Priority Prevention: Annual Conference**
9 A.M.-5 P.M.—Holiday Inn, Jamesburg
(NJ Coalition for Prevention of Developmental Disabilities)

29 **Sleep Disorders**
12 Noon-5 P.M.—Mercer Medical Center, Trenton
(AMNJ)

ONCOLOGY & RADIATION ONCOLOGY

March

4 **Annual Clinical Abstract Meeting**
1:30-5 P.M.—The Manor, West Orange
(Oncology Society of New Jersey)

19 **Tumor Board Conference**
12:15-1:15 P.M.—Mercer Medical Center, Trenton
(Mercer Medical Center)

25 **Cocktail Reception**
6:30-9 P.M.—The Manor, West Orange
(Radiation Oncology Section, AMNJ)

April

16 **Tumor Board Conference**
12:15-1:15 P.M.—Mercer Medical Center, Trenton
(Mercer Medical Center)

PEDIATRICS

March

17 **5th Annual Perspectives on Sudden Infant Death Syndrome**
9 A.M.-3 P.M.—Sheraton Gardens, Freehold
(NJ SIDS Resource Center)

19- **Pediatric Life Support**
20 8 A.M-4 P.M.—UMDNJ-Medical Science Building, Newark
(UMDNJ)

PSYCHIATRY

March

4 **Psychiatric Aspects of AIDS**
2:30-3:30 P.M.—Ancora Psychiatric Hospital, Hammonton
(AMNJ)

4 **Psychopharmacology of Depression in Children**
8:30-10 A.M.—Elizabeth General Medical Center, Elizabeth
(EGMC)

April

15 **Medical and Psychiatric Aspects of Drug and Alcohol Abuse**
2:30-3:30 P.M.—Ancora Psychiatric Hospital, Hammonton
(AMNJ)

RADIOLOGY

March

19 **Radiology Lecture**
1:30-5 P.M.—Saint Barnabas Medical Center, Livingston
(Saint Barnabas Medical Center)

19 **MRI Conference and Case Presentation**
7:30-9:30 P.M.—Saint Barnabas Medical Center, Livingston
(Radiological Society of NJ and Diagnostic Radiology Section)

April

16 **Radiology Lecture**
1:30-5 P.M.—Saint Barnabas Medical Center, Livingston
(Saint Barnabas Medical Center)

16 **MRI Conference and Case Presentation**
7:30-9:30 P.M.—Saint Barnabas Medical Center, Livingston
(NJ Institute of Ultrasound in Medicine, Radiological Society of New Jersey, and Diagnostic Radiology Section, AMNJ)

SURGERY AND ITS SPECIALTIES

April

4 **Annual Meeting**
9 A.M-1 P.M.—Nassau Inn, Princeton
(NJ Society of Plastic and Reconstructive Surgeons)

8 **New Wrinkles in Facial Cosmetic Surgery**
10:30-11:30 A.M.—St. Mary's Hospital, Passaic
(AMNJ)

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IN MEMORIAM

JOSEPH A. ADAMCIK

A member of our Passaic County component, Joseph Anton Adamcik, MD, passed away on October 22, 1991. Dr. Adamcik was born in Passaic on April 28, 1915. He was awarded a medical degree from the State University of New York–Downstate Medical Center, in 1950. After completing an internship at Jersey City Medical Center, in 1951, Dr. Adamcik completed residencies at Newark City Hospital and the Orthopedic Center for Crippled Children and Adults, both in Newark. Dr. Adamcik received his license to practice medicine in New Jersey in 1952. Dr. Adamcik served in the United States Navy during World War II. Dr. Adamcik's medical career included: school physician for Passaic High School and Paterson State Teachers College; affiliation with the Orthopedic Center for Crippled Children and Adults, UMDNJ, and Harrison S. Martland Memorial Center, all in Newark, and St. Francis Hospital, Port Jervis, New York; member of the Academy of Medicine of New Jersey and of the American Medical Association; and assistant medical director of New Jersey Bell Telephone Company, Newark. Dr. Adamcik practiced in Port Jervis, New York; Passaic; and Montague. Dr. Adamcik specialized in orthopedics and psychiatry.

MICHAEL L. ANDERSON

At the untimely age of 38, Michael Louis Anderson, MD, of Vineland, passed away on August 24, 1991; he was born in Philadelphia on November 15, 1952. Dr. Anderson graduated from the University of Medicine and Dentistry of New Jersey (UMDNJ)–New Jersey Medical School, Newark, in 1984. The following year, Dr. Anderson received his New Jersey medical license. He completed a residency and internship at UMDNJ, Newark. Dr. Anderson, specializing in general and vascular surgery, was on staff at Bridgeton Hospital, Millville Hospital, and Newcomb Hospital, Vineland. He was a surgeon with Davies, O'Donnell & Davies Surgical Association, Millville, since 1989. Dr. Anderson's military career included: medical corpsman in the United States Navy from 1970 to 1976, veteran of the Vietnam conflict, and captain in the United States Army Medical Corps. Dr. Anderson was a member of our Cumberland County component and of the American Medical Association.

ROBERT H. ARESON

We regret to inform you of the death of Robert Hallett Areson, MD, on October 12, 1991. Dr. Areson was born in Montclair on November 25, 1915; he resided and practiced in Montclair, and retired to Savannah, Georgia. He was awarded a medical degree from Yale University School of Medicine in 1941. After completing an internship in 1942 at University Hospitals, Cleveland, Dr. Areson served as a lieutenant commander in the United States Navy from 1942 to 1946, stationed óverseas for three years. Following his military service, Dr. Areson completed a residency at Pratt Diagnostic Hospital and Cushing VA Hospital. Dr. Areson

received his New Jersey medical license in 1949. An internist, Dr. Areson had practiced in Montclair since 1949, and was affiliated with The Mountainside Hospital, Montclair, and with Essex County Isolation Hospital, Belleville. Dr. Areson's medical career included: past-president of our Essex County component and of the New Jersey Diabetes Association; diplomate of the American Board of Internal Medicine; and fellow of the American College of Physicians. Dr. Areson also was a member of the American Medical Association.

JOSEPH S. BERMAN

We have received word of the death of Joseph S. Berman, MD, on December 10, 1990. Dr. Berman, born in 1914, earned his medical degree from Chicago Medical School, Illinois, in 1944. An anesthesiologist, Dr. Berman maintained a practice in Toms River and was affiliated with Point Pleasant Hospital, Toms River, and Newark Beth Israel Medical Center. He was a member of our Ocean County component, and of the American Medical Association. Dr. Berman was a fellow of the American College of Anesthesiologists.

BERNARDO FISZER

Born on July 7, 1931, in Buenos Aires, Argentina, Bernardo Fiszer, MD, died on October 6, 1991. Dr. Fiszer was 60 years old. Dr. Fiszer was awarded a medical degree from the University of Buenos Aires Medical School, Argentina, in 1959, and practiced medicine in Buenos Aires for one year before relocating to the United States in 1960. After completing an internship at Lutheran Medical Center, Brooklyn, New York, and a residency at St. Michael's Medical Center, Newark, Dr. Fiszer received his New Jersey medical license in 1967. Dr. Fiszer was a staff physician with Columbus Hospital, Newark, assistant attending at Elizabeth General Medical Center, and clinical assistant at St. Elizabeth Hospital, Elizabeth. He practiced in Elizabeth. Dr. Fiszer specialized in obstetrics and gynecology. He was a member of our Union County component and of the American Medical Association. He resided in Brooklyn, New York; Irvington; and Springfield. Dr. Fiszer served in the Argentine Army in 1952.

GEORGE C. FREEMAN

An Army veteran of both World Wars, 92-year-old George Camp Freeman, MD, died on September 9, 1991. Dr. Freeman was born in West Orange on July 29, 1899; he was awarded his medical degree from Cornell University Medical College, New York, in 1928. In 1930, Dr. Freeman received his New Jersey medical license. Dr. Freeman maintained a practice in Maplewood. In addition, Dr. Freeman's long medical career included employment with the employee health service department of Prudential Insurance Company, Newark. He was a member of our Essex County component, of the American Medical Association, of the New Jersey Association of Industrial Physicians and Surgeons, and of the Passaic Township Board of Health; and past-president of the Industrial Medical Association. Dr. Freeman specialized in industrial medicine. He resided in Millington and Hackettstown.

JOHN H. HUBBARD

We regret to announce the death of John Harvie Hubbard, MD, at the untimely age of 56. Dr. Hubbard was born on October 9, 1935, in Detroit, Michigan; he passed away on Oc-

tober 10, 1991. Dr. Hubbard earned his medical degree from Tulane University School of Medicine, New Orleans, Louisiana, in 1961. He completed an internship at Cleveland Clinic Hospital, Ohio, in 1962, and served residencies at Cleveland Clinic Hospital; Montefiore Medical Center, New York; and Bronx Municipal Hospital Center, New York. Dr. Hubbard also completed a fellowship at Albert Einstein College of Medicine, New York, in 1966. Dr. Hubbard received his Louisiana, New York, and Pennsylvania medical licenses in 1961, 1965, and 1970, respectively. During his medical career, Dr. Hubbard was assistant professor at the University of Pennsylvania, Philadelphia, and at Montefiore Medical Center; a member of our Bergen County component and of the American Medical Association; and a diplomate of the American Board of Neurological Surgery. Dr. Hubbard specialized in neurological surgery; he practiced in Philadelphia, Paramus, and Hackensack. Dr. Hubbard was attending at Hackensack Medical Center; Englewood Hospital; and Albert Einstein Hospital, New York; and chief at Pascack Valley Hospital and Holy Name Hospital. Dr. Hubbard served in the United States military from 1967 to 1970.

GEORGE J. KOHUT

Perth Amboy resident George John Kohut, MD, died on July 5, 1991, at the age of 82. Dr. Kohut was born in Trenton on March 6, 1909. In 1936, Dr. Kohut was awarded a medical degree from the University of Budapest, Hungary. After completing an internship at Holy Name Hospital, Teaneck, Dr. Kohut received his New Jersey medical license in 1937. Dr. Kohut was an anesthesiologist at Raritan Bay Medical Center, Perth Amboy, for many years, serving as director of anesthesiology before retiring in 1978. Dr. Kohut was past-president and treasurer of our Middlesex County component, and a member of the American Medical Association and of the New Jersey and American Societies of Anesthesiologists. During World War II, Dr. Kohut was a captain in the United States Air Force.

HERMAN KUPPER

Eighty-one-year-old Herman Kupper, MD, passed away on October 18, 1991. Dr. Kupper was born in Jaroslaw, Poland, on July 17, 1910. In 1939, he was awarded a medical degree from the University of Bologna, Italy. Dr. Kupper received his license to practice medicine in New Jersey in 1955. A general practitioner, Dr. Kupper practiced in Newark, and was on staff at VA Medical Center, East Orange. Dr. Kupper resided in Newark and East Orange. He was a member of our Essex County component, of the American Medical Association, and of the Academy of Medicine of New Jersey.

LAWRENCE J. MAZZEI

On October 20, 1991, Lawrence Joseph Mazzei, MD, of Hackettstown, passed away at the age of 65. Dr. Mazzei specialized in internal medicine. He was born on October 11, 1926, in Union City. After he was awarded a medical degree from the University of Bologna, in 1955, Dr. Mazzei completed an internship in 1957 at St. Mary Hospital, Hoboken, and residencies at Saint Michael's Hospital, Newark, in 1959 and VA Hospital, Fort Howard, Maryland, in 1960. In 1957, Dr. Mazzei received his New Jersey medical license. During Dr. Mazzei's medical career, he served as medical director of the House of Good Shepherd,

Hackettstown; as staff physician at Hackettstown Community Hospital; and as internist at the State Correctional Facility at Annandale and High Point. Dr. Mazzei maintained a private practice in Hackettstown, Englewood, and Oakland. He was a member of our Bergen and Warren County components and of the American Medical Association. Before relocating to Hackettstown, Dr. Mazzei resided in Cliffside Park. Dr. Mazzei is a World War II United States Navy veteran.

HAROLD SCHWARTZ

Obstetrician and gynecologist Harold Schwartz, MD, died on October 14, 1991. Dr. Schwartz was born in Brooklyn on October 14, 1910. He attended the University of Vienna, Austria, and was awarded a medical degree in 1936. Dr. Schwartz completed postgraduate work at McGill University, Montreal. He received his New Jersey medical license in 1939. Dr. Schwartz served a residency and internship at Newark Beth Israel Medical Center. He began his medical career with a practice in Harrison. After serving in the United States Navy during World War II, where he was awarded the Purple Heart and the Bronze Star, Dr. Schwartz maintained a practice in Newark before relocating his practice to Millburn. During his career, Dr. Schwartz also was an associate professor at UMDNJ–New Jersey Medical School, Newark; on staff at Newark Beth Israel Medical Center and Saint Barnabas Medical Center; a member of our Essex County component, of the American Medical Association, of the Academy of Medicine of New Jersey, of the New Jersey Society of Obstetricians and Gynecologists, and of the New Jersey Society of Cytology; a diplomate of the American Board of Obstetrics and Gynecology; and a fellow of the American Society of Cytology and of the American College of Obstetricians and Gynecologists. Dr. Schwartz resided in Newark and Short Hills.

LORING E. SYLVESTER

A Salem County physician for the past 35 years, Loring Ermond Sylvester, MD, died on August 23, 1991. Dr. Sylvester was born in Bryn Mawr, Pennsylvania, on August 16, 1926. He attended the University of Pennsylvania School of Medicine, Philadelphia, and was awarded a medical degree in 1949. He served an internship and residency at the Graduate Hospital of the University of Pennsylvania, Philadelphia. In 1956, he received his New Jersey medical license. Dr. Sylvester was a general surgeon. From 1978 to 1988, Dr. Sylvester was chief of surgery at The Memorial Hospital of Salem County, and chief of the medical staff from 1988 to 1990. Most notably, Dr. Sylvester introduced gastrointestinal endoscopy to Salem County when the specialty was in its infancy. During his medical career, Dr. Sylvester was clinical assistant professor at the Medical College of Pennsylvania, Philadelphia; affiliated with the Medical Center of Delaware, Wilmington; a member of our Salem County component; a diplomate of the American College of Surgeons; a fellow of the American College of Surgeons, serving as the cancer liaison physician on the Commission of Cancer; and a member and past-president of the Salem County Chapter of the American Cancer Society. Dr. Sylvester was a United States Navy veteran; he also served in the Korean War aboard the U.S.S. *Shenandoah*.

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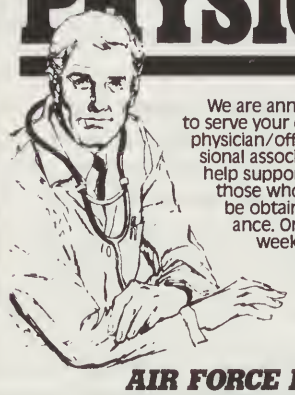
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Description: Yohimbine is a 3a-15a-20B-17a-hydroxy Yohimbine-16a-carboxylic acid methyl ester. The alkaloid is found in Rubaceae and related trees. Also in Rauwolfia Serpentina (L) Benth. Yohimbine is an indolalkylamine alkaloid with chemical similarity to reserpine. It is a crystalline powder, odorless. Each compressed tablet contains (1/12 gr.) 5.4 mg of Yohimbine Hydrochloride.

Action: Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalmic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

Indications: Yocon® is indicated as a sympathicolytic and mydriatric. It may have activity as an aphrodisiac.

Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.[1,2] Also dizziness, headache, skin flushing reported when used orally.[1,3]

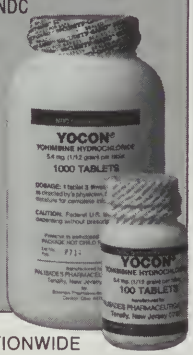
Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.[1,3,4] 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to ½ tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.[3]

How Supplied: Oral tablets of Yocon® 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

References:

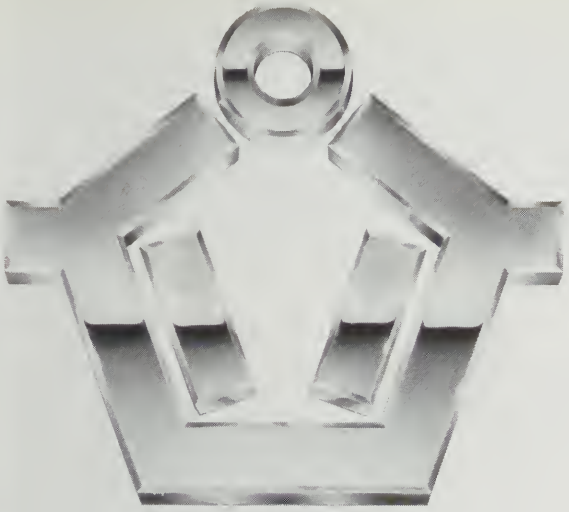
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2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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Zantac®

ranitidine HCl/Glaxo 150 mg and 300 mg tablets

Zantac® 150 Tablets **BRIEF SUMMARY**
(ranitidine hydrochloride)

Zantac® 300 Tablets
(ranitidine hydrochloride)

Zantac® Syrup
(ranitidine hydrochloride)

The following is a brief summary only. Before prescribing, see complete prescribing information in Zantac® product labeling.

INDICATIONS AND USAGE: Zantac® is indicated in:
1. Short-term treatment of **active duodenal ulcer.** Most patients heal within four weeks.
2. **Maintenance therapy** for duodenal ulcer patients at reduced dosage after healing of acute ulcers.
3. The treatment of **pathological hypersecretory conditions** (eg, Zollinger-Ellison syndrome and systemic mastocytosis).
4. Short-term treatment of **active, benign gastric ulcer.** Most patients heal within six weeks and the usefulness of further treatment has not been demonstrated.
5. Treatment of **gastroesophageal reflux disease (GERD).** Symptomatic relief commonly occurs within one or two weeks after starting therapy. Therapy for longer than six weeks has not been studied.

In active duodenal ulcer; active, benign gastric ulcer; hypersecretory states; and GERD, concomitant antacids should be given as needed for relief of pain.

CONTRAINDICATIONS: Zantac® is contraindicated for patients known to have hypersensitivity to the drug.

PRECAUTIONS:

General: 1. Symptomatic response to Zantac® therapy does not preclude the presence of gastric malignancy.
2. Since Zantac is excreted primarily by the kidney, dosage should be adjusted in patients with impaired renal function (see DOSAGE AND ADMINISTRATION). Caution should be observed in patients with hepatic dysfunction since Zantac is metabolized in the liver.

Laboratory Tests: False-positive tests for urine protein with Multistix® may occur during Zantac therapy, and therefore testing with sulfosalicylic acid is recommended.

Drug Interactions: Although Zantac has been reported to bind weakly to cytochrome P-450 *in vitro*, recommended doses of the drug do not inhibit the action of the cytochrome P-450-linked oxygenase enzymes in the liver. However, there have been isolated reports of drug interactions that suggest that Zantac may affect the bioavailability of certain drugs by some mechanism as yet unidentified (eg, a pH-dependent effect on absorption or a change in volume of distribution).

Carcinogenesis, Mutagenesis, Impairment of Fertility: There was no indication of tumorigenic or carcinogenic effects in lifespan studies in mice and rats at doses up to 2,000 mg/kg/d.

Ranitidine was not mutagenic in standard bacterial tests (*Salmonella, Escherichia coli*) for mutagenicity at concentrations up to the maximum recommended for these assays.

In a dominant lethal assay, a single oral dose of 1,000 mg/kg to male rats was without effect on the outcome of two matings per week for the next nine weeks.

Pregnancy: ***Teratogenic Effects: Pregnancy Category B:*** Reproduction studies have been performed in rats and rabbits at doses up to 160 times the human dose and have revealed no evidence of impaired fertility or harm to the fetus due to Zantac. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

Nursing Mothers: Zantac is secreted in human milk. Caution should be exercised when Zantac is administered to a nursing mother.

Pediatric Use: Safety and effectiveness in children have not been established.

Use in Elderly Patients: Ulcer healing rates in elderly patients (65 to 82 years of age) were no different from those in younger age groups. The incidence rates for adverse events and laboratory abnormalities were also not different from those seen in other age groups.

ADVERSE REACTIONS: The following have been reported as events in clinical trials or in the routine management of patients treated with Zantac®. The relationship to Zantac therapy has been unclear in many cases. Headache, sometimes severe, seems to be related to Zantac administration.

Central Nervous System: Rarely, malaise, dizziness, somnolence, insomnia, and vertigo. Rare cases of reversible mental confusion, agitation, depression, and hallucinations have been reported, predominantly in severely ill elderly patients. Rare cases of reversible blurred vision suggestive of a change in accommodation have been reported.

Cardiovascular: As with other H_2-blockers, rare reports of arrhythmias such as tachycardia, bradycardia, atrioventricular block, and premature ventricular beats.

Gastrointestinal: Constipation, diarrhea, nausea/vomiting, abdominal discomfort/pain, and rare reports of pancreatitis.

Hepatic: In normal volunteers, SGPT values were increased to at least twice the pretreatment levels in 6 of 12 subjects receiving 100 mg qid intravenously for seven days, and in 4 of 24 subjects receiving 50 mg qid intravenously for five days. There have been occasional reports of hepatitis, hepatocellular or hepatocanalicular or mixed, with or without jaundice. In such circumstances, ranitidine should be immediately discontinued. These events are usually

Zantac® 150 and 300 (ranitidine hydrochloride) Tablets
Zantac® (ranitidine hydrochloride) Syrup

reversible, but in exceedingly rare circumstances death has occurred.

Musculoskeletal: Rare reports of arthralgias.

Hematologic: Blood count changes (leukopenia, granulocytopenia, thrombocytopenia) have occurred in a few patients. These were usually reversible. Rare cases of agranulocytosis, pancytopenia, sometimes with marrow hypoplasia, and aplastic anemia have been reported.

Endocrine: Controlled studies in animals and man have shown no stimulation of any pituitary hormone by Zantac and no antiandrogenic activity, and cimetidine-induced gynecomastia and impotence in hypersecretory patients have resolved when Zantac has been substituted. However, occasional cases of gynecomastia, impotence, and loss of libido have been reported in male patients receiving Zantac, but the incidence did not differ from that in the general population.

Integumentary: Rash, including rare cases suggestive of mild erythema multiforme, and, rarely, alopecia.

Other: Rare cases of hypersensitivity reactions (eg, bronchospasm, fever, rash, eosinophilia), anaphylaxis, angioneurotic edema, and small increases in serum creatinine.

OVERDOSAGE: Information concerning possible overdosage and its treatment appears in the full prescribing information.

DOSAGE AND ADMINISTRATION: (See complete prescribing information in Zantac® product labeling).

Active Duodenal Ulcer: The current recommended adult oral dosage is 150 mg or 10 ml (2 teaspoonfuls equivalent to 150 mg of ranitidine) twice daily. An alternate dosage of 300 mg or 20 ml (4 teaspoonfuls equivalent to 300 mg of ranitidine) once daily at bedtime can be used for patients in whom dosing convenience is important. The advantages of one treatment regimen compared to the other in a particular patient population have yet to be demonstrated.

Maintenance Therapy: The current recommended adult oral dosage is 150 mg or 10 ml (2 teaspoonfuls equivalent to 150 mg of ranitidine) at bedtime.

Pathological Hypersecretory Conditions (such as Zollinger-Ellison syndrome): The current recommended adult oral dosage is 150 mg or 10 ml (2 teaspoonfuls equivalent to 150 mg of ranitidine) twice a day. In some patients it may be necessary to administer Zantac® 150-mg doses more frequently. Doses should be adjusted to individual patient needs, and should continue as long as clinically indicated. Doses up to 6 g/d have been employed in patients with severe disease.

Benign Gastric Ulcer: The current recommended adult oral dosage is 150 mg or 10 ml (2 teaspoonfuls equivalent to 150 mg of ranitidine) twice a day.

GERD: The current recommended adult oral dosage is 150 mg or 10 ml (2 teaspoonfuls equivalent to 150 mg of ranitidine) twice a day.

Dosage Adjustment for Patients with Impaired Renal Function: On the basis of experience with a group of subjects with severely impaired renal function treated with Zantac, the recommended dosage in patients with a creatinine clearance less than 50 ml/min is 150 mg or 10 ml (2 teaspoonfuls equivalent to 150 mg of ranitidine) every 24 hours. Should the patient's condition require, the frequency of dosing may be increased to every 12 hours or even further with caution. Hemodialysis reduces the level of circulating ranitidine. Ideally, the dosage schedule should be adjusted so that the timing of a scheduled dose coincides with the end of hemodialysis.

HOW SUPPLIED: Zantac® 300 Tablets (ranitidine hydrochloride equivalent to 300 mg of ranitidine) are yellow, capsule-shaped tablets embossed with "ZANTAC 300" on one side and "Glaxo" on the other. They are available in bottles of 30 (NDC 0173-0393-40) tablets and unit dose packs of 100 (NDC 0173-0393-47) tablets.

Zantac® 150 Tablets (ranitidine hydrochloride equivalent to 150 mg of ranitidine) are white tablets embossed with "ZANTAC 150" on one side and "Glaxo" on the other. They are available in bottles of 60 (NDC 0173-0344-42) and 100 (NDC 0173-0344-09) tablets and unit dose packs of 100 (NDC 0173-0344-47) tablets.

Store between 15° and 30° C (59° and 86° F) in a dry place. Protect from light. Replace cap securely after each opening.

Zantac® Syrup, a clear, peppermint-flavored liquid, contains 16.8 mg of ranitidine hydrochloride equivalent to 15 mg of ranitidine per 1 ml in bottles of 16 fluid ounces (one pint) (NDC 0173-0383-54).

Store between 4° and 25° C (39° and 77° F). Dispense in tight, light-resistant containers as defined in the USP/NF.

July 1990

Glaxo Pharmaceuticals
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Research Triangle Park, NC 27709

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Zantac®

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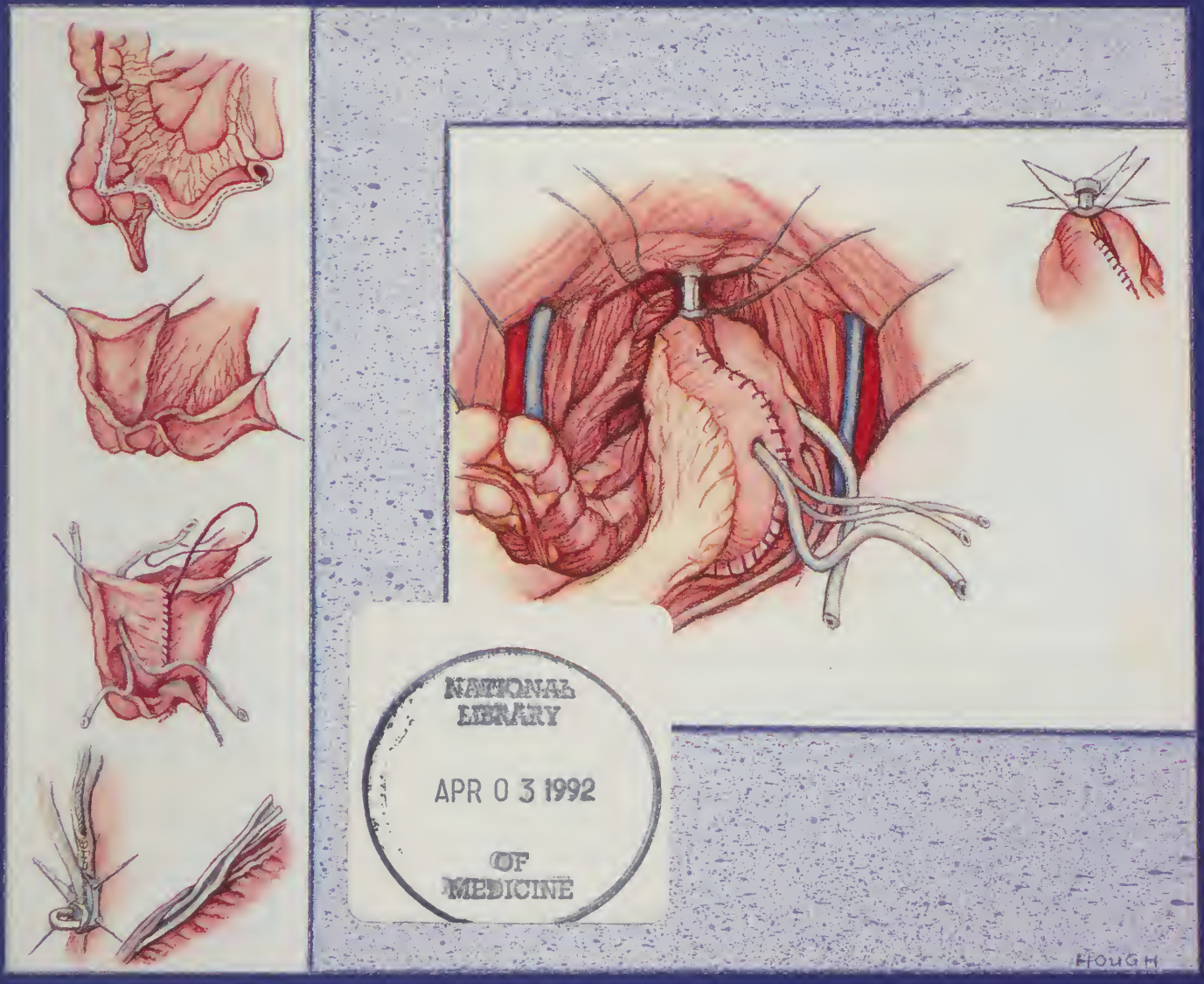
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Newswatch

MSNJ COMMENTS ON PHASE 1 OF THE STATE HEALTH PLAN

Centralized state planning is the key feature of the proposed State Health Plan developed by the administration in Trenton. The Plan is a model for total regulation, leaving little if any room for marketplace competition and consumer choice.

The State Health Plan would close dozens of community inpatient pediatric services; inflexibly regionalize obstetric services; reduce capital expenditures for hospitals to a ridiculously low amount; end all physician ownership in referral facilities; prohibit physicians from referring patients to any health service provider; establish strict regulatory procedures and requirements for all high-technology services; ban new cardiac services; prevent new nursing homes from being built; and take thousands of hospital beds out of the system without regard to demands caused by AIDS, demographic changes, and huge demands for critical care beds.

The Plan is a blueprint for second-class care. As a monument to centralized state planning, it is an exercise in total regulation. The Plan would cost our state thousands of jobs and several hundreds of millions of dollars in hospital revenues. The fundamental flaw in the Plan is that it fails to allow any room for consumer choice and marketplace competition.

Physicians must be proactive in promoting ways to improve health care and contain costs through the marketplace. To that end, the Medical Society of New Jersey (MSNJ) is recommending creation of a statewide task force on consumer choice to help support informed decisions about health insurance, hospital services, and medical treatments. MSNJ also suggests a task force be created to propose ways to cut administrative costs, which are the bane of private practices and the whole health care system.

A detailed report on the Plan, including almost 70 suggestions for making the Plan more democratic, reasonable, and supportive of high-quality, efficient, universally accessible health care, is available to all interested physicians. A summary of the report follows.

I. Character of State Health Planning

* Each chapter should be restructured to identify major components of quality of care and to present recommendations for preserving or improving quality.

* Each recommendation for new regulation should be justified with an explicit benefit-cost analysis that takes into account both the direct and indirect cost of regulation. The direct costs should be described in terms of specific state expenditures and an explanation

of where revenue for those expenditures will be generated, given the current state budget deficit. The analysis also should reveal that the proposed regulatory program is more cost effective than all other reasonable alternatives.

* To reduce ideologic bias, one or more consultants from private industry should be engaged to review the chapters to assure that all reasonable alternatives are presented.

* The State Health Planning Board should request the New Jersey State Department of Health (NJDOH) -- unless NJDOH does so on its own -- to create a joint private-public sector task force to prepare a chapter on administrative costs. This chapter would present recommendations for reducing expenditures without jeopardizing quality of care. There also should be a definitive joint task force to present a draft chapter on malpractice reforms.

II. Process of Developing a State Health Plan

* From now on, each draft chapter of the State Health Plan should be developed by a task force composed of actual representatives of interested groups and organizations.

* To limit resistance and bitterness associated with the way that Phase 1 chapters were developed, and to avoid institutionalizing hasty decisions, all Phase 1 chapters should be sunset 12 months after they take effect. This would allow for a more open process in making lasting decisions in these vital areas.

* The State Health Plan should include only broad directions. Decisions about specific health facilities should be made on the local level, subject to review on the state level. Also, local advisory boards (LABs) should select their own representatives to the State Health Planning Board, under conditions that each LAB establishes for itself.

* Legislation should be enacted to postpone the effective date of Phase 1 of the Plan, to allow for revisions consistent with suggestions made by MSNJ and others.

III. Health Care Regulation in New Jersey

* A task force on consumerism should be established to explore issues of patient choice, patient-practitioner communication, and consumer information. The task force should move New Jersey toward the provision of standardized information on health care prices and quality, with recognition of the serious methodologic problems involved in producing such information.

* Legislation should be considered to revamp the Health Care Trust Fund, so that it has a board of trustees empowered to make reasonable cost-containment decisions, such as channeling patients to less costly services that

also would be reimbursed by the Fund. Higher taxes on tobacco and alcohol products should be used to establish a financial base for the trust fund, because consumption of these products creates a need for health care.

* Reasonable fee schedules and extensions of coverage for Medicaid should be proposed by the administration. Even if the current budget deficit prevents implementation of Medicaid reimbursement changes at this time, the changes should be prepared and circulated for implementation later.

* The State Health Planning Board should challenge the administration to develop a comprehensive strategy for confronting social problems that surface, ultimately, in health care.

IV. Demographics

* The writers should include projections for population increases among the elderly, especially the over-85 population that heavily needs and uses health services.

* The State Health Planning Board should conduct a special, open hearing on the needs of Hispanics and Asian-Americans.

V. Long-term Care

* We support efforts to develop the proposed alternatives to nursing home care. However, the Plan must include contingencies in case the alternatives prove insufficient to meet the demand for long-term care placements by our growing elderly population. These contingencies should be matched to triggers to assure that elderly people will not be caught in a bind caused by utopian planning.

* The administration must put forward regulatory and financing alternatives for nursing home care, with an emphasis on incentives for quality.

VI. Maternal and Child Health

* While implementation of Phase 1 of the State Health Plan is postponed, as suggested in Part II of these comments, NJDOH should work closely with outside groups to explore ways to enhance the positive effects of regionalization while preventing adverse effects on health.

VII. Cardiovascular Diseases

* The governor should forcefully declare a smoke-free New Jersey as a state goal. Also, the administration should announce and take efforts to discourage drug stores from selling tobacco products.

* A ban on new cardiac services in New Jersey is unwarranted. The certificate-of-need process contains

enough controls. Recommendations for special limitations on cardiac care should be eliminated.

VIII. High Technology

* If NJDOH is going to devote an entire chapter to new regulatory initiatives to contain costs, that chapter should address an area of enormous expenditure and very low benefit to patients. In other words, the chapter on high technology should be mothballed until more pressing topics, such as regulatory oppression, are handled.

IX. Addictions

* The recommendations should be recast as a concrete and reasonable plan. We believe that the Plan should concentrate on alcohol and drug abuse, and MSNJ offers resources to help address these problems.

X. Acute Care Hospital Services

* The regulators should place less emphasis on mandated bed closures, and more emphasis on financial incentives, in promoting hospital efficiency. Because New Jersey is one of the few states that regulate hospital reimbursement, financial incentives are within the state's arsenal.

* A task force on critical care needs should be established by NJDOH, under auspices of the State Health Planning Board, as an urgent priority. Our citizens, especially in urban areas, deserve no less.

* LABs must not be steamrolled into acquiescing to pediatric bed closures without adequate community participation in the decisions. LABs, and not centralized state authorities, should hold decision-making power over specific closures. Also, the choice of sites for children's hospitals should be supported by a thorough discussion of alternatives, criteria, and current and projected utilizations so that the choices do not appear political.

* The capital portion of the draft chapter should be rejected. The State Health Planning Board should create a task force, staffed independently of the administration and reporting directly to the Board, to develop a draft capital policy.

* NJDOH, Division of AIDS Prevention and Control, should be asked to project increased needs for inpatient care under alternative scenarios. These projections should be reflected clearly in the objectives for bed capacity.

* The State Health Planning Board should request NJDOH to present a comprehensive strategy for maintaining and promoting high-quality care in New Jersey.

March 1992

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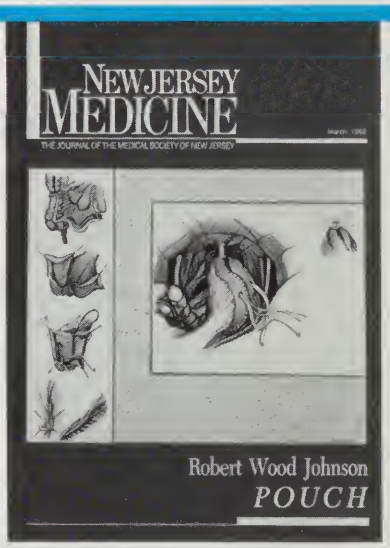
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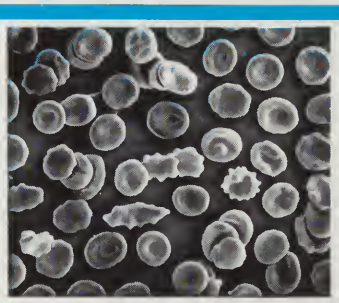
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The Cover

Drs. Barone and Cummings are the winners of the 1991 MSNJ Writing Competition for their report on a technique for orthotopic bladder substitution. Cover: Jean Hough.



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MSNJ NEWSLETTER

DR. COYE SPEAKS OUT

New Jersey's past health commissioner, Molly Joel Coye, MD, MPH, is reaching out to physicians in her new role as California's director of health services, the nation's most important state health administrator. In a cover story interview with *California Physician,* the magazine of the California Medical Association, Dr. Coye stated that practicing physicians "are our sentinels who let us know what we need to do for the health of the public," and she termed listening to physicians as "one of my most important responsibilities."

Dr. Coye further expressed support for revamping Medi-Cal as a managed care system attractive to providers. She noted the importance of monitoring disease prevention programs to show their success. And, she came out against a "single-payer" approach to health financing—also known as national health insurance.

ACTIONS BY SBME

The State Board of Medical Examiners (SBME) gave final approval to regulations concerning the professional practice structure, professional fees and investments, and brain death. A summary of the regulations and SBME actions follows.

N.J.A.C. 13:35-6.16: Professional Practice Structure

6.16(a)—Permits professional (corporate) practice if the name of the corporate entity consists of the names of the owners. Approved with minor wording changes.

6.16(b)—Entity must establish policies and procedures on staffing, practice audit, security, "medical policies," cleanliness, equipment inspection, record-keeping, billing, and maintenance of a list of current fees. Approved.

6.16(c)—A notice must be posted, stating: "INFORMATION ON PROFESSIONAL FEES IS AVAILABLE TO YOU ON REQUEST." Approved.

6.16(d)—A licensee must be on-site when the medical service is performed. Approved with minor change.

6.16(e)—A licensee of SBME may invest in a health facility ("health care service") only if it is owned solely by licensed health professionals. Each licensee is responsible for the facility's adherence to professional practice standards. If a licensee refers a patient to a facility in which the licensee has invested, the referral must be justified in the patient record. Approved over the objections of Dr. Grossman.

6.16(f)—(1) A licensee may only employ practitioners whose scopes of practice are within the employer's scope of practice. (2) In a partnership, each practitioner shall work in "the same or in a closely allied medical or professional health care field." Letterheads, advertisements, and other notices shall designate each practitioner's field. (3) A licensee may not be employed by someone with a more limited license. (4) An employed licensee may provide health services only in a health care setting. (5) If a practice is managed by a professional management corporation, the physician still is accountable. Approved.

6.16(g)—A licensee shall sever any economic relationship with an entity upon acquiring knowledge that the entity is regularly violating paragraph (b) or (c) above. Approved without discussion.

6.16(h)—A licensee may

participate in a managed care plan that does not restrict professional judgment or prevent appropriate referrals. Approved without discussion.

6.16(i)—To close loopholes in federal CLIA-88 legislation protecting off-premises laboratories, this paragraph requires truth-in-billing and listing of all owners' names in all written communications involving such facilities. Approved.

6.16(j)—Physicians are responsible for compliance with paragraphs (b) and (c) in physical therapy facilities in which the physician is involved. Again, the name of any such entity must include the physician's name. Approved without discussion.

6.16(k)(1)-(2)—Compliance with (b) and (c) also is required in the case of radiologic services. Approved without substantive discussion.

6.16(k)(3)—A physician investing in a radiologic service shall file a detailed annual report with SBME. Defeated.

6.16(l)—Compliance with (b) and (c) also is required for ophthalmology.

Note: In paragraphs (i)-(l) above, billing must be in the physician's or physician office's name, if services are rendered in the office.

6.16(m)—At the request of the Division of Consumer Affairs, SBME deferred implementation of Sec. 6.16 until April 8, 1992.

6.17—Professional Fees and Investments, Prohibition of Kickbacks.

6.17(a)—Definitions approved without discussion.

6.17(b)—Disclosure of financial interest is required when a practitioner refers a patient to a health care service in which the practitioner or an immediate family member has a significant beneficial interest. Disclosure includes furnishing the patient with a written notice that follows a prescribed format. Approved.

6.17(c)—A licensee may not give or receive a gift that "a reasonable person" would recognize as payment for referrals or related behavior. Approved without discussion.

6.17(d)—A licensee shall not charge for free samples. Approved without discussion.

6.17(e)(1)—A licensee may only charge his own actual cost plus 10 percent for medications, medical goods, and medical devices. Approved.

6.17(e)(2)—This paragraph initially specified how to bill separately for supplying prescribed items. The paragraph was deleted, but it was agreed to leave open ("reserve") a paragraph 2, to signal SBME's intent to consider revision in subsequent months.

6.17(e)(3)-(4)—The patient may insist that the prescribing practitioner monitor the provision, by another practitioner, of a prescribed item, such as eyeglasses. Hearing aid dispensers are exempt from the cost-plus-10 percent rule in (e)(1). Approved without substantive discussion.

6.17(f)—A licensee may receive payment from a managed care plan which is not contingent on limits on the licensee's "medical discretion." Approved without discussion.

6.17(g)—Licensees may not invest in an entity offering health services or equipment that pays dividends on a basis other than return on monetary investment. Approved without discussion.

6.17(h)—Licensees may invest in real estate used for professional practices only if remuneration is based solely on return on monetary investment or fair market value. Licensees may rent office space only if the arrangement does not involve referrals or other economic behaviors. Approved without discussion.

6.17(i)—Licensees may invest in medical equipment but are responsible for assuring compliance with **6.16(b)-(c)**. Approved without discussion.

6.17(j)—Licensees with a significant beneficial interest in a health care service must so notify SBME within one year.

In addition, SBME approved

regulations on brain death: Two physicians (the attending and a neurologist or neurosurgeon) must certify brain death. And, SBME voted unanimously against A-5210, which would require posting of fees in physician offices.

POISON INFORMATION & EDUCATION

Information about adverse drug reactions, drug interactions, dosages for renal dialysis patients, drug cautions for nursing mothers, and unapproved drug uses, as well as drug identification, may be obtained 24 hours a day, seven days a week, from the New Jersey Poison Information and Education System (NJPIES). The System uses on-line computer and abstracting services to complement its own reference library. Serving as medical director of NJPIES is Steven M. Marcus, MD, of Essex County. Call 1/800/962-1253.

BALANCE BILLING

A New York law limiting the amount a physician may "balance bill" Medicare patients to levels stricter than the federal government's limits is not pre-empted by federal law and does not violate the 14th amendment or supremacy clause of the United States Constitution, a federal court holds.

PRO ACTIVITIES

Funding cuts of about 30 percent are likely for the next three fiscal years for Medicare peer review organizations (PROs), necessitating significant cutbacks in PRO activities and scaled back implementation of the Uniform Clinical Data Set system, according to a top American medical peer review official.

MEDICAL CONSULTANTS WANTED

The federal government is seeking qualified, board certified or board eligible physicians to perform expert medical evaluations of civilian federal employees with injuries or diseases of occupational origin related to their federal job. The program is administered by the Office of Worker's Compensation Program (OWCP) of the United States Department of Labor, and provides medical and salary benefits for disabled federal workers with job-related conditions.

Evaluations, to include physical examination and indicated testing, are needed in compensation cases for a meaningful second opinion regarding ongoing medical care and/or proposed surgery; or for an impartial referee opinion when a conflict of medical opinion exists and/or for determination of the extent of permanent impairment using the *AMA Guide to the Evaluation of Permanent Impairment.*

If you are interested in participating, send name, address, telephone number, state license number, tax I.D., specialty, subspecialty, and a brief curriculum vitae to: Dr. Sidney M. Samis, District Medical Director, U.S. Department of Labor—OWCP, 201 Varick Street, Rm. 750, New York, NY 10014.

AMERICAN NURSES ASSOCIATION

Higher Medicare reimbursement for nurses and the ability to bill Medicare separately are legislative priorities of the American Nurses Association (ANA), but those goals may conflict with the federal government's interest in controlling health care costs, ANA members were told at the Association's recent nursing reimbursement conference.

County and Specialty Societies, Academy of Medicine of New Jersey, MSNJ Auxiliary, and AMA Delegation Attendance at Meetings of the Board of Trustees

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December 15 ..... John G. Winant, Jr, MD

New Jersey State Society of Anesthesiologists

July 21 ..... Stanley Bresticker, MD
Anthony R. Giorgio, MD
September 15 ..... Roger A. Moore, MD
October 20 ..... Stanley Bresticker, MD
Anthony R. Giorgio, MD
Roger A. Moore, MD
November 17 ..... Stanley Bresticker, MD
Roger A. Moore, MD

Electrodiagnosis Medicine Association of New Jersey

July 21 ..... Kutumba S. Pitta, MD
Michael Sutula, DO
September 15 ..... Michael Sutula, DO
October 20 ..... Kutumba S. Pitta, MD
Michael Sutula, DO
November 17 ..... Michael Sutula, DO

New Jersey Chapter, American College of Emergency Physicians

July 21 ..... Christopher J. Minas, MD
September 15 ..... Richard M. Schwab, MD
December 15 ..... Richard M. Schwab, MD

New Jersey Society of Internal Medicine

September 15 ..... Frank J. Malta, MD
December 15 ..... Frank J. Malta, MD

New Jersey Association of Medical Specialty Societies

July 21 ..... Stanley Bresticker, MD
October 20 ..... Stanley Bresticker, MD
November 17 ..... Stanley Bresticker, MD

New Jersey Obstetrical and Gynecological Society

July 21 ..... John D. Franzoni, MD
October 20 ..... John D. Franzoni, MD
November 17 ..... John D. Franzoni, MD
December 15 ..... John D. Franzoni, MD

Occupational Medical Association of New Jersey

July 21 ..... Lorraine A. Sims, MD

New Jersey Academy of Ophthalmology and Otolaryngology

November 17 ..... Edwin M. Trayner, MD
December 15 ..... Saul M. Tischler, MD
Edwin M. Trayner, MD

New Jersey Orthopaedic Society

October 20 ..... Morton Farber, MD
Casey K. Lee, MD

New Jersey Pediatric Society

September 15 ..... Barry S. Prystowsky, MD

New Jersey Society of Physical Medicine and Rehabilitation

July 21 ..... Kutumba S. Pitta, MD
October 20 ..... Kutumba S. Pitta, MD

New Jersey Society of Thoracic Surgeons

September 15 ..... Ronald M. Abel, MD

Academy of Medicine of New Jersey

July 21 ..... Gerald Shapiro, MD, President
Ronnie Davidson, EdD, Dir., Research & Education
Sherman Garrison, MD

September 15 ..... Gerald Shapiro, MD, President
Charles J. Heitzmann, Executive Director

October 20 ..... Gerald Shapiro, MD, President
Charles J. Heitzmann, Executive Director
Ronnie Davidson, EdD, Dir., Research & Education
Sherman Garrison, MD

November 17 ..... Gerald Shapiro, MD, President
Charles J. Heitzmann, Executive Director
Ronnie Davidson, EdD, Dir., Research & Education
Sherman Garrison, MD

December 15 Charles J. Heitzmann, Executive Director
Sherman Garrison, MD

Medical Society of New Jersey Auxiliary

July 21 ..... Marion Geib, President-Elect

September 15 ..... Marion Geib, President-Elect

October 20 ..... Jean Taboada, President
Marion Geib, President-Elect

November 17 ..... Jean Taboada, President
Marion Geib, President-Elect
Dorothy Camangian, President, Hudson County Auxiliary

December 15 ..... Marion Geib, President-Elect

AMA Delegation

AMA Delegates

July 21 ..... Harry M. Carnes, MD
Karl T. Franzoni, MD
John S. Madara, MD
Joseph N. Micale, MD
Henry J. Mineur, MD
Joseph A. Riggs, MD
Edward A. Schauer, MD
Robert H. Stackpole, MD
William E. Ryan, MD

September 15 ..... Harry M. Carnes, MD
Ralph J. Fioretti, MD
Karl T. Franzoni, MD
John S. Madara, MD
Joseph N. Micale, MD
Henry J. Mineur, MD
Joseph A. Riggs, MD
Edward A. Schauer, MD
Robert H. Stackpole, MD
William E. Ryan, MD

October 20 ..... Harry M. Carnes, MD
Ralph J. Fioretti, MD
Karl T. Franzoni, MD
John S. Madara, MD
Joseph N. Micale, MD
Henry J. Mineur, MD
Joseph A. Riggs, MD
Edward A. Schauer, MD
William E. Ryan, MD

November 17 ..... Ralph J. Fioretti, MD
Karl T. Franzoni, MD
John S. Madara, MD
Henry J. Mineur, MD
Joseph A. Riggs, MD
Edward A. Schauer, MD
Robert H. Stackpole, MD
William E. Ryan, MD

December 15 ..... Harry M. Carnes, MD
Ralph J. Fioretti, MD
Karl T. Franzoni, MD
Joseph N. Micale, MD
Joseph A. Riggs, MD
Robert H. Stackpole, MD
William E. Ryan, MD

AMA Alternate Delegates

July 21 ..... Douglas M. Costabile, MD
Paul J. Hirsch, MD
Donald J. Holtzman, MD
A. Ralph Kristeller, MD
Mark T. Olesnicky, MD
Irving P. Ratner, MD
Robert J. Weierman, MD

September 15 ..... Joel S. Cherashore, MD
Douglas M. Costabile, MD
Paul J. Hirsch, MD
Donald J. Holtzman, MD
A. Ralph Kristeller, MD
Mark T. Olesnicky, MD
Irving P. Ratner, MD
Carl Restivo, Jr, MD
Robert J. Weierman, MD

October 20 ..... Joel S. Cherashore, MD
Douglas M. Costabile, MD
George T. Hare, MD
Paul J. Hirsch, MD
A. Ralph Kristeller, MD
Mark T. Olesnicky, MD
Irving P. Ratner, MD
Carl Restivo, Jr, MD
Robert J. Weierman, MD

November 17 ..... Douglas M. Costabile, MD
Paul J. Hirsch, MD
Donald J. Holtzman, MD
A. Ralph Kristeller, MD
Mark T. Olesnicky, MD
Robert J. Weierman, MD

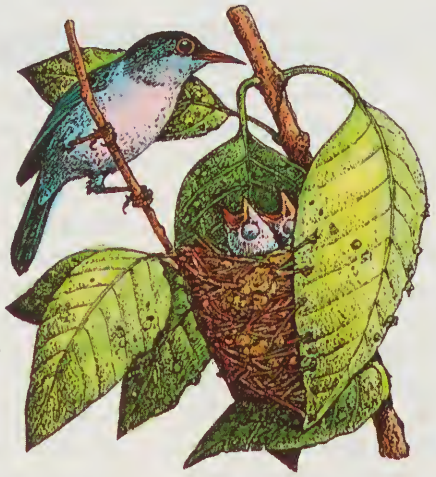
December 15 ..... Joel S. Cherashore, MD
Douglas M. Costabile, MD
George T. Hare, MD
Paul J. Hirsch, MD
A. Ralph Kristeller, MD
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PROFESSIONAL LIABILITY

COURT DECISIONS

Pain, suffering, and coma. A trial court in Brooklyn, New York, has decided that a jury could properly award damages for pain and suffering to a comatose patient. According to experts, the medical record indicated that the patient, who died after 40 days in a coma, was unaware of any pain or suffering. But, the judge determined that a jury could reasonably come to the opposite conclusion, declaring: "Lay opinions may compete with medical opinions where the issue relates to matters cognizable by either."

Hospital liability for physician negligence. A faculty physician, summoned by residents on duty in a hospital emergency room, was found negligent for performing an appendectomy and diagnosing a ruptured corpus luteum cyst, when subsequent surgery revealed endometriosis and a complete bowel obstruction allegedly caused by the faculty member's actions.

The hospital denied responsibility, stating that the faculty physician was not an employee of the hospital. But, West Virginia's high court ruled that the physician was an "ostensible agent" of the hospital. A hospital with an emergency department open to the public may not escape liability by claiming that department personnel are not its agents, declared the court.

Halcion® and Prozac®. In a letter to the nation's physicians, Upjohn Company has agreed to pay defense costs and any settlements or judgments involving claims of injuries from approved uses of the sleeping pill, Halcion®. "This product is safe and effective when it is used as recommended," the manufacturer assured. Eli Lilly and Company has offered to pay for claims against the antidepressant Prozac®.

REIMBURSEMENT

Mandatory insurance: The future is in Hawaii. Former Massachusetts Governor Michael S. Dukakis, titular leader of the Democratic Party, is promoting Hawaii's system of mandatory health insurance as a model for the nation. In a recent journal article, Dukakis and coauthor, Professor Cyril Roseman of the University of Hawaii, contend that "the health state" is only two to three years away from achieving "universal access to health care at affordable cost."

Under the State Health Insurance Program (SHIP), uninsured residents are obtaining coverage under a plan financed by general revenue. Hawaii employers long have been required to provide health insurance to employees, typically through Blue Cross/Blue Shield. The state intends to use primary care physicians as SHIP "gatekeepers" responsible for approving all specialty referrals in return for a capitated case-management fee.

Critics may attribute the feasibility and low cost of Hawaii's approach to a generally healthy population. Hawaiians boast the nation's highest life expectancy and one of its lowest infant mortality rates.

Meanwhile, "not on his radar screen" is how "the Duke" assesses the health care policy development performance of President Bush. "He just hasn't been in the room," says Mr. Dukakis of President Bush.

Managed care in Maryland. A trend may be emerging in Maryland, which has created a Maryland Access to Care (MAC) program requiring Medicaid recipients to choose a primary care physician or clinic. Nationwide interest in tying Medicaid benefits to case management is rising in a nearly desperate effort to curtail rises in Medicaid expenditures. Kentucky already uses the case-management approach, and California and other large states are contemplating it. The approach is popular with the Florio administration, which has been championing case management through the Garden State HMO.

Managed care in Arizona. Data from Arizona, the pioneer in case management for the medically indigent, suggest that the approach does save money. According to California-based economists Lynn Paringer and Nelda McCall, costs of the Arizona Health Care Cost Containment System, a Medicaid alternative, rose only 34.2 percent between 1983 and 1989, compared to a 60.7 percent increase in comparable Medicaid costs.

THE POLITICS OF HEALTH

Why did Wofford win? How the question is asked may determine whether health care reform was the issue that decided Pennsylvania's special Senate election in November, when interim Senator Harris Wofford, a liberal Democrat, upset former governor and United States At-

torney General Dick Thornburgh, for the seat of the late John Heinz.

Inspired by a comment by an ophthalmologist, Senator Wofford aired a television commercial declaiming: "If criminals have the right to a lawyer, I think working Americans should have the right to a doctor."

In a postelection survey conducted by the Harvard Program on Public Opinion and Health Care, 50 percent of the respondents listed national health insurance as one of the two issues that most influenced their vote. This rating was as high as the number two and number three issues—taxes and jobs—combined. Moreover, large numbers of voters said that someone in their household was staying in a job only to retain health benefits—a new phenomenon termed "job lock."

But, in a bipartisan survey financed by the Health Insurance Association of America, 57 percent of the voters said that their vote was intended primarily as a message to President Bush, and only 14 percent of these voters identified national health insurance as their message. In this survey, only 19 percent of Wofford voters said they voted for him on the basis of the health insurance issue.

Regardless of the relative importance of health issues in the Pennsylvania election, it is clear that the Republican candidate failed to respond effectively to his opponent's health offensive. Democrats now are busy seeking to exploit the health insurance issue, and a Wofford campaign adviser, James Carville, the "ragin' Cajun," is assisting such Democratic notables as Governor Bill Clinton and reportedly Governor Jim Florio.

Physician attitudes. Fifty-nine percent of United States physicians favor major health care reform, according to a recent Harris poll. But, physicians have their own ideas about the chief causes of rising health care costs, citing malpractice premiums, defensive medicine, medical technology, uncontrolled drug prices, and patient behavior. Other groups tend to cite physician and hospital pricing behavior as a major factor in medical inflation.

MALPRACTICE VERDICTS

Judgment against house staff. After being struck in the head with a blunt instrument, a 40-year-old patient was brought to a New Jersey hospital emergency department at 1:00 A.M. and admitted to an inpatient floor at 5:00 A.M., when a nurse observed that one of the patient's pupils was fixed and dilated. The nurse summoned the house staff physician, who arrived one hour later, examined the patient, and left. Shortly afterward, the nurse contacted a neurosurgeon, who came to the hospital and performed surgical evacuation of an epidural hematoma. The treatment delay of more than one hour allegedly resulted in brain damage causing permanent left-sided hemiparesis and deficits in memory and concentration.

The physician attributed the delay to his need to respond to an emergency in the hospital intensive care unit, and to the failure of the nurse to summon the neurosurgeon as instructed. The nurse contended that she eventually contacted the neurosurgeon on her own initiative, and that the house staff physician had never asked her to do so. The nurse's detailed notes supported her version of the events, and the physician was unable to identify the intensive-care patient who allegedly needed his attention.

The New Jersey jury came in with a verdict of $1,631,000 for the plaintiff, whose care was estimated to cost $120,000 per year for life but who had a "spotty" work history and lost earnings that were calculated at only $9,600 per year. The verdict was reduced by 40 percent, the portion of the injury that the jury found was attributable to the head trauma itself. The nurse was exonerated.

ENT treatment of dermatologic condition. An otorhinolaryngologist treated his clerical employee's dermatologic condition with Oxsoralen®, after they examined the *Physicians' Desk Reference (PDR)* entry for the drug. While driving, she subsequently exposed her hands to sunlight, allegedly resulting in second-degree burns, a ten-day hospitalization, and painful debridements.

In testimony in a New Jersey courtroom, the physician and his employee disagreed whether he had assured her that a *PDR* warning about sunlight need not be taken seriously, noting that manufacturers place warnings even about extremely rare reactions. Later, the injuries resolved, but the employee-cum-patient claimed a psychiatric reaction. The jury found the physician 60 percent negligent and the plaintiff 40 percent comparatively negligent, and its award of $10,000 was reduced accordingly.

Same result with dermatologic care. In Colorado, a dermatologist was found liable for burns suffered by a patient treated with Oxsoralen®. Exposure to sunshine resulted in injuries to the feet and legs. The patient claimed that he should have been advised of the dangerous effects of the drug that can result from improper use, and the physician claimed that the exposure was twice as long as directed. The *PDR* warning was entered into evidence. A verdict of negligence was affirmed by the state court of appeals.

Chiropractic care. A $472,483 judgment against a chiropractor was affirmed by a Connecticut appeals court. A 76-year-old man, whose spine allegedly was brittle,

received a back adjustment from the chiropractor, and the next day received another adjustment, described as only a soft-tissue manipulation, from a second chiropractor. The patient's back condition worsened, and eventually he underwent surgical removal of two extruded disc fragments and the decompression of his spinal cord. The jury cleared the second chiropractor of negligence. Both chiropractors admitted that they did not inform the patient of risks or alternative treatments—because, they said, they considered the therapy to be without risk.

Emotional distress of patient unaware of cancer. On vacation in Maine, a woman visited a hospital emergency department after injuring her hip and wrist. X-rays were taken, and the radiologist's report noted "an ill-defined density in the upper left lobe" of the chest and recommended investigation and monitoring. This finding and recommendation were not passed on to the patient, however.

Nine months later, home in California, the patient was diagnosed with cancer of the left lung. She died 11 months later. Postmortem pathology reports indicated that, due to the advanced state of the cancer, even treatment begun at the time of the Maine vacation would have proved fruitless. Accordingly, the trial court in Maine awarded summary judgment for the Maine physicians for the claim of wrongful death and the claim of emotional distress. The state's high court reversed the emotional distress ruling, however, to permit a jury to decide that the patient suffered anguish, that was not unreasonable, over the time lost for treatment.

Refusal to treat. Can a physician who happens to be present in a hospital emergency department be found liable for refusing to treat a patient suffering a heart attack? Yes, says Kentucky's Supreme Court.

The patient's brother brought the patient, a coal miner, to the hospital from work. The brother repeatedly asked the physician for help, and the physician consistently declined to provide assistance. Finally, the brother drove the patient to another hospital some 30 minutes away. Death from myocardial infarction occurred the next day.

The physician won a directed verdict from the trial court, and won his first appeal. However, the high court ruled that the physician could be held liable if a jury finds that his refusal to treat was a substantial factor in the patient's death.

Right patient, wrong surgery. A 28-year-old childless newlywed was scheduled to receive a dilation and curettage and laparoscopy. Instead, she received a tubal ligation and became sterile. The patient settled with her obstetrician-gynecologist, who performed the surgery. She went to trial against the New Jersey hospital and a circulating nurse who failed to advise the physician that the patient who originally had been scheduled to receive the ligation was delayed, and that the schedule was being changed to advance the plaintiff into surgery.

The plaintiff claimed extensive emotional damages. The jury found the physician 75 percent negligent and the hospital 25 percent negligent. An award of $400,000 to the plaintiff and $100,000 to her husband was molded accordingly. The absence of the physician as a courtroom target may have prevented a larger award.

Comminuted radial fracture. The plaintiff's claim in this New Jersey trial arising from a basketball injury was that the orthopedic surgeon negligently failed to fixate the fracture, inserting pins into metacarpals on the ulnar side, rather than the radial side of the hand, and into the ulnar, rather than the radius proximally, and negligently removed the pins and cast before bony union was achieved. The plaintiff claimed an injury of a shortening of the radius of up to one-half inch and a deformity in which the hand points 45 degrees to the radial side, restricting motion and causing pain and weakness in the nondominant hand. Previously employed as a carpenter and plumber, the plaintiff complained that he no longer can use tools, although he made no claim of lost earnings.

The defendant's expert contended that proper alignment had taken place. The expert further argued that use of the ulna was justified in the interest of reducing the risk of injury to vessels and nerves caused by insertion of the pins. The adverse outcome, the defense maintained, was a result of the unusually severe fracture itself.

The jury found for the plaintiff and awarded a $350,000 verdict. The jury apparently was impressed by the fact that the fragments moved out of alignment shortly after surgery, when the arm was immobilized, and by the fact that only one reference in the medical record characterized the fracture as severe. The plaintiff also had contended that the defendant had removed the cast even before taking an x-ray, implementing a generalized time frame of six weeks rather than keeping the cast on for as long as the particular case required.

Cardiac catheterization. A New Jersey cardiologist was cleared in a malpractice action involving a cardiac catheterization. The patient claimed that the procedure should not have been done until noninvasive tests were conducted, and that the cardiologist withdrew the catheter with excessive force, causing severe bleeding, a scrotal hematoma 13 inches in diameter, and continuing pain and sexual dysfunction. The physician asserted that catheterization was necessary in light of the patient's unstable angina, that bleeding is a recognized risk that occurs in the absence of negligence, that the bleeding was immediately re-

cognized and properly treated, and that the plaintiff's continuing complaints were without merit.

Failure to diagnose breast cancer. An internist prescribed Premarin® for menstrual discomfort, and a radiologist interpreted a mammogram as negative. Later, the 50-year-old patient was diagnosed with breast cancer, and entered more than 10 years of radical surgery, chemotherapy, radiotherapy, and coronary bypass surgery necessitated by effects of chemotherapy. A jury in New York State found the internist 75 percent negligent and the radiologist 25 percent negligent, and awarded more than $1.9 million in damages. An appellate court dismissed the claim against the radiologist and held the internist liable for $900,000 in damages for pain and suffering.

MALPRACTICE POLICY DEVELOPMENTS

Peer reviewer immunity. In enacting the Health Care Quality Improvement Act of 1986 that created the National Practitioner Data Bank, Congress also granted immunity to medical peer reviewers from damages suffered by reviewed physicians. However, the immunity is very limited, notes *Hospital Law Newsletter*. If the plaintiff demonstrates by a preponderance of the evidence that all of four standards were not met, peer reviewers can face tort or antitrust liability. The four standards are:

1. The reviewer reasonably believed that the action was in the furtherance of quality health care.
2. The action was taken after a reasonable effort was made to obtain the facts.
3. The physician received adequate notice and opportunity for a hearing or other appropriate procedural safeguards.
4. The reviewer reasonably believed that the action was justified by the facts.

Not only is the grant of immunity rather limited, but also the law leaves several key questions unanswered: Is compliance with the four standards to be decided by the judge or the jury? How is compliance determined? Is the decision about compliance to be made before trial, in a bifurcated trial, in an immediately appealable order during the trial process, or in the first part of a two-part trial? The *Newsletter* suggested that before trial, in a motion for summary judgment, the judge should decide whether the plaintiff's allegations would support a jury's finding that the defendant failed to meet the standards.

Punitive damages. If the defendant's conduct was willful or intentional, and accompanied by aggravating circumstances that amount to gross negligence or malice, courts throughout the United States permit awards of punitive damages above and beyond the usual tort damages for medical expenses, lost earnings, and pain and suffering. In malpractice cases, notes the periodical *Medical Malpractice Reports*, awards for punitive damages are "relatively rare." And, last year, the United States Supreme Court ruled that punitive damage awards require "meaningful judicial scrunity." *Pacific Mutual Life Insurance Co. v. Haslip*, 111 S.Ct. 1032 (1991).

One factor justifying punitive damages is the wealth of the defendant. An award should be large enough, in relation to the defendant's wealth, to materially punish the defendant, and small enough to lie within the defendant's ability to pay.

An example cited for punitive damages in malpractice involved a psychiatrist's administration of between 141 and 171 sodium pentothal treatments to a patient at a charge of $75 to $100 per incident. Early on, the treatments revealed that the patient had been abused as a child, but the psychiatrist did not disclose this finding to the patient. Experts testified that the nondisclosure and almost all of the treatments violated the standard of care, and that the patient had become addicted to the chemical.

MALPRACTICE TIPS

Anticoagulant therapy. One-fifth of the total indemnity paid for drug therapy cases by the Pennsylvania Medical Association Liability Insurance Company since 1978 has involved anticoagulant therapy. The company has advised physicians to consider the patient's situation carefully before embarking on therapy, and to analyze the risks and benefits involving each of the following variables: rate, morbidity, and mortality of thromboembolism without anticoagulation; the reduction in the rate of thromboembolism that the therapy is expected to achieve; rate, morbidity, and mortality of complications, especially hemorrhage; and effects of therapy on quality of life.

These factors should be discussed with the patient during the informed-consent process. Risk factors for hemorrhage include intensity of anticoagulation, severe anemia, malignancy, recent surgery or trauma, severe and uncontrolled hypertension, concomitant drug therapy including aspirin, poor patient compliance—and inadequate physician supervision.

AIDS ISSUES

The Medical Society of New Jersey (MSNJ) has learned that an underwriter of worker's compensation insurance in the state may be discontinuing coverage of office-based physicians who

engage in laboratory, surgical, or blood work in their offices.

In a complaint to the New Jersey State Department of Insurance, MSNJ argued that cancelling coverage of such physicians "lacks any reasonable, empirical, or scientific basis" and "discriminates against the great majority of physicians, against providers of services to HIV-positive individuals, and, indirectly, against people with HIV or AIDS." Nevertheless, the Department has ruled that insurers are free to underwrite whom they wish, and noted that a state plan is available to provide coverage at equivalent rates to employers who cannot obtain coverage from a voluntary insurer.

MSNJ is considering taking additional action.

BIOMEDICAL ETHICS

An international conference, "Bioethics in a Changing World," will be held in Cambridge, England, August 9 to 14, 1992. Topics include: withholding treatment, euthanasia, criteria for death, abortion, surrogacy, rationing of health care, ethics by committee, and genetic technology. In addition, participants may apply for research support for individual projects to be completed by May 31, 1993. Registration for nonmembers of the International Bioethics Institute is $675 before June 15, 1992. Contact the International Bioethics Institute, 1721 Mar West, Tiburon, CA 94920-1932.

PROFESSIONAL LIABILITY

This commentary is a regular feature of *NEW JERSEY MEDICINE*. Authors are James E. George, MD, JD, director, Professional Liability Control, MSNJ, and Neil E. Weisfeld, JD, MSHyg, director, Education, Research & Regulatory Affairs, MSNJ. □



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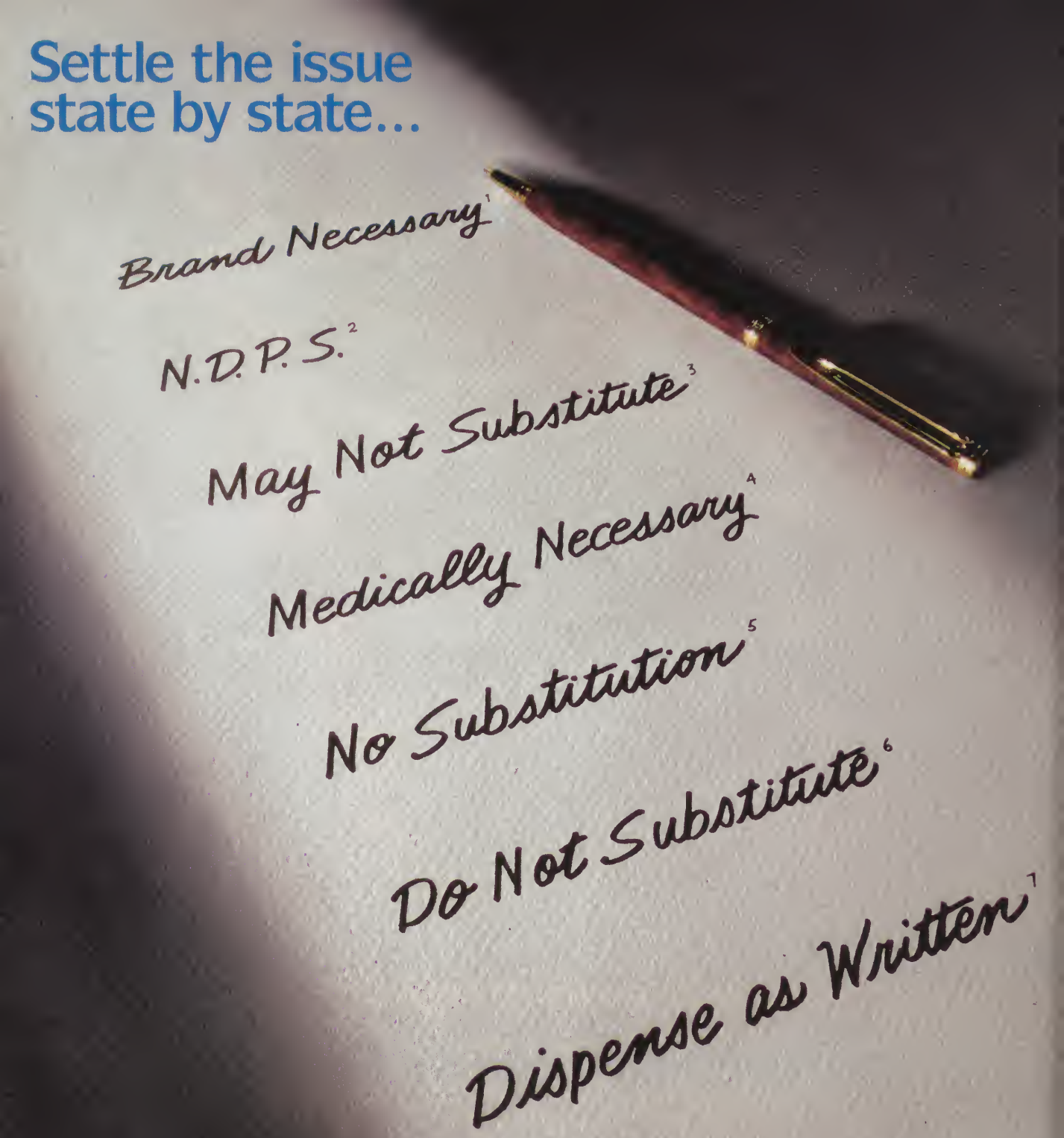
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BOOK REVIEWS

ANDREW TAYLOR STILL: 1828-1917

Carol Trowbridge. Kirksville, MO, The Thomas Jefferson University Press, 1991. This book is a fascinating and important addition to the meagre literature about the origins of osteopathy. It is the first biography of Andrew Taylor Still, the founder of a 19th-century drugless American medical reform movement that evolved into the mainstream of modern medical practice. The author had access to manuscripts in the possession of the descendants that were unavailable to earlier writers. The result is a portrait of Still that raises more questions than it answers about the intellectual origins of high theories. One questions why the author apparently neglected to cite Still's second and revised edition of his *Autobiography*, a major primary source.

Ms. Trowbridge divided the book into two parts. The first section provides an expanded body of information about Still's family and his life as the son of a Methodist circuit rider in the Kansas-Missouri area. Still's activities as a farmer, physician, abolitionist member of the free Kansas legislature, and officer in the Kansas militia during the Civil War are fully described. The second section entitled, "The Journey of Andrew Taylor Still," details the story of his intellectual pilgrimage to find an alternative theory for the treatment of disease. This search was stimulated by Still's frustration with the failure of traditional medical practice to save three of his children from spinal meningitis. The author relates the influence of the pseudoscientific movements of mesmerism, spiritualism, and phrenology on the development of Still's theory.

The focus of Ms. Trowbridge's interpretation is an attempt to demonstrate that Still profoundly was influenced by his contemporary, the British evolutionist-philosopher Herbert Spencer. Though tempting, the result is not wholly convincing.

Ms. Trowbridge has provided a much broader and immensely valuable spectrum of intellectual possibilities that may have influenced the development of Still's theories of osteopathy. However, Still did not choose to reveal the soucres of his ideas—a problem that will always confront and challenge the historian. ☐ Robert L. Thompson, EdD

CONTINENCE PROMOTION IN GENERAL PRACTICE

Nigel Smith; Maggie Clamp. New York, NY, Oxford University Press, 1991. This book is exactly what it says it is: a practical guide to the management of urinary incontinence. It is one of several practical guides published by Oxford University Press.

This is a good text to have available at nurses' stations in hospitals and nursing homes, to be used as a text for nursing students, or for the general practitioner questioned by patients. For the nurse or physician who cares enough to want to help, this book offers all one needs to know.

There are a few intriguing British expressions like "toileting" and "St. Peter's boat" (female urinal). Overall, *Continence Promotion in General Practice* is a useful book that can be perused in an hour. Hopefully the book will find its way to those who can apply its lessons toward relieving real suffering. ☐ Robert B. Zufall, MD

HANDBOOK OF SKIN CLUES OF SYSTEMIC DISEASES

T.C. Ford; J.M. Graham. Oxford, UK, Bio Scientific Publishers, 1991. The British have done it again. They have written a text dealing with a technically sophisticated topic and created a readable book for those interested in learning the appropriate applications of centrifugation. The 120-page, soft-covered text explains what centrifugation is, what it does and its limitations, and how it does it. The first section covers the basic principles of centrifugation. The second section describes the applications as well as practical methods for the purification of each class of biological materials, e.g. proteins, DNA, cell organelles, intact cells. The appendices actually are "cookbooks" with recipes for the specialized centrifugation techniques. The appendices also list the manufacturers, models, and types of centrifuges and rotors currently available. The book clearly is directed to individuals in the biological sciences or in medicine. ☐ Leonard Bielory, MD

INTRODUCTION TO CENTRIFUGATION

Paul H. Jacobs, MD; Todd S. Anhalt, MD. Philadelphia, PA, Lea and Febiger, 1992. The skin and the eyes often are considered the "windows" for the evaluation of systemic diseases. This soft-covered, 150-page book, intentionally written as a superficial clinical text, is an excellent introduction for the neophyte interested in a variety of cutaneous signs. The table of contents lists a variety of cutaneous manifestations of systemic illness including cyanosis, erythema multiforme and erythema nodosum, hyperpigmentation, papules and nodules, plaques, pruritus, purpura, ulcerations, urticaria, vesiculobullous lesions, vitiligo, and nail changes. Each section provides a differential diagnosis with a separate column listing suggested serological and diagnostic tests to assist the clinician. This book certainly is worth looking at for the uninitiated clinician who wishes some assistance in the analysis of cutaneous lesions. ☐ Leonard Bielory, MD

MEDICAL ODYSSEYS

Allan B. Weisse, MD. New Brunswick, NJ, Rutgers University Press, 1991. In our technologically charged times, some people tend to believe that medical discoveries result from research that leads in an orderly way from observation to deduction. Not so, according to Allan Weisse, MD, a skilled storyteller and medical historian, in a rich and compelling compendium of some of the more fascinating stories behind the stories regarding a number of the outstanding advances in medicine in this century entitled, *Medical Odysseys: The Different and Sometimes Unexpected Pathways to Twentieth Century Medical Discoveries.*

The author, a cardiologist and professor of medicine at UMDNJ-New Jersey Medical School, Newark, shows how the combination of serendipity, luck (both good and bad), and rediscovery of old ideas lead to new insights.

In personal interviews with many contemporary scientists, Dr. Weisse probes the details of their discoveries to uncover the sources of motivation and find out how their discoveries happened.

The book begins with the story of mercury, a toxic but fascinating substance, erstwhile used in the treatment of syphilis. The chance observation that certain syphilitic patients with heart failure manifested a brisk diuresis when treated with mercury led to the establishment of this agent as one of the earliest successful diuretics.

In other tales, Dr. Weisse describes the search for the viruses of hepatitis and the evolu-

tion of cardiac surgery, from finger fracture for mitral stenosis through coronary artery bypass to cardiac transplantation and the artificial heart. The discovery and rediscovery of penicillin is explored, as is the development of hemodialysis for the treatment of acute and chronic renal failure. In the latter, the story behind the story combines medical, sociological, historical, and circumstantial factors that embellish this revolutionary phenomenon.

Other revelations include the heart pacemaker, polio vaccine, and the recognition and treatment of pernicious anemia. One of the most remarkable stories is the development of effective cancer chemotherapy, in the chapter entitled, "From Trench Warfare to the War on Cancer."

What makes this book special is the "up close and personal" style with which Dr. Weisse introduces the reader to the people and personalities behind the events. Medical progress in these examples does not emerge from some dark laboratory but derives from individuals with strongly felt commitments and personal involvements.

This book will be enjoyed by all persons with an interest in medical history, which comes alive through the author's incisive observations. ☐ Alan J. Lippman, MD

EATING, BODY WEIGHT, AND PERFORMANCE IN ATHLETES

Kelly Brownell, PhD; Judith Rodin, PhD; Jack Wilmore, PhD. Philadelphia, PA, Lea & Febiger, 1992. In 374 pages, this text covers all aspects of nutrition as it relates to the athlete, and, in essence, to everyone. Following a general introduction, the first section covers the basic issues, such as determinants of food intake, body weight regulation, and body composition, and then relates these factors to the performance and training of athletes. The next section deals with eating and weight problems. The third section discusses how eating disorders directly affect the athlete, including weight loss or gain, and menstrual dysfunction. A final chapter in this section covers the psychological and physiological effects of overtraining. The last section of the book suggests management methods for the problems described, and discusses the "pressure to perform" that modern competitors face.

The book is written by well-qualified authors. While there is an overlap of topics, the repetition emphasizes important issues. This book is recommended to those working with athletes. ☐ Christine E. Haycock, MD

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LETTERS AND VIEWPOINTS

VIRAL POLITICS: AN END TO THE GAME

The sides have been chosen. It is the public against physicians in the AIDS hysteria game: demands from doctors that patients be tested and a public outcry that doctors be tested. Genuine scientific facts are being clouded in a sea of emotional and political rhetoric. Despite the fact that an epidemic the scope of the great plague now is beginning, the AIDS issue still is being treated as a political, not a medical, issue. The time has come to face scientific and medical facts: AIDS can and will plunder through the world's population unless a vaccine is found quickly. The virus has long since left the exclusive province of homosexuals and intravenous drug abusers. It now is thriving in mainstream America; in your carpenter, in the car salesman, in your child's teacher, and in your child. Politics must be put aside in order to treat this catastrophe medically. Prevention of the spread of the disease, of course, must begin with education—education of high-risk populations, including teenagers.

But there are hidden risks to this epidemic. Risks that must be controlled now. Can the virus be transmitted via improperly sterilized instruments? There is no reason to think otherwise. Virologists have long known that, contrary to public and doctors' perceptions, this is a hardy virus that is capable of surviving for weeks in a drop of dried blood. Because of this, physicians, dentists, and podiatrists must take great care to properly sterilize their instruments in the office. This may mean a change of technique. Viral kinetics vary from bacterial kinetics and what may have been acceptable technique for the killing of 99.999 percent of bacteria to eliminate the possibility of an infectious inoculum may not be adequate to prevent the single virion from infecting and eventually causing AIDS. Standards must be followed to assure good medical care and the public's perception of good medical care.

I would suggest that, as a minimum, all instruments be subjected to a two-stage cleansing and sterilization process. This would include ultrasonic cleansing to remove particulate matter, followed by steam/heat autoclaving for an extended period of time. Health professionals who cannot perform this simple task should not perform procedures in the office. Physicians, dentists, and podiatrists who use instruments that cannot be entirely cleaned with this technique and would require gas sterilization techniques, need to arrange for this. The key to this public health measure would be the universal testing of all patients before all procedures. HIV-positive patients would require the gas sterilization of instruments such as dental handpieces following their procedures. These handpieces cannot be completely and unequivocally sterilized with other techniques. Knowledge of which patients are HIV positive would allow for adequate sterilization of instruments. If this cannot be assured, then these patients should be directed to hospital clinics that are capable of assuring proper sterilization techniques. Devices such as high-speed dental drills cause aerosolization of saliva, complete with viral particles, and procedures should be performed in an operatory equipped with high-powered laminer flow venting devices.

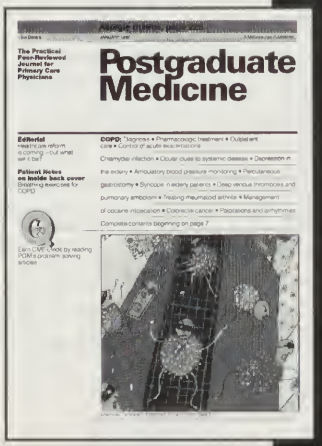
Once these sterilization techniques are standardized, the public will have more assurance that viral diseases will not be transmitted via their doctor. A challenging, perhaps more frightening, problem, however, involves the transmission of viral disease by lay practitioners. Tattoo artists, electrolysists, ear piercers, manicurists, and barbers routinely violate the integument during the course of their procedures. How many of these people have a knowledge of sterilization techniques? Who taught them these techniques? Who is policing their techniques? These are frightening thoughts.

The time has come for a response from the medical community to this problem. We face a public health disaster if we delay. ☐ Arthur W. Perry, MD

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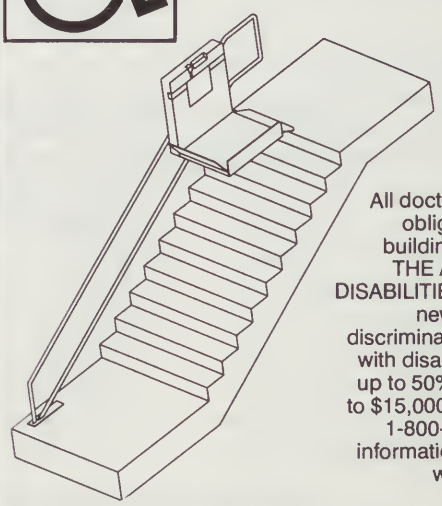
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EDITOR'S DESK

A MINORITY REPORT?

There have been many complaints about the actions of the Department of Health and Human Services (HHS) and its Health Care Financing Administration (HCFA) regarding their handling of the Medicare program. Why have they gone to a resource-based relative value scale (RBRVS) that nobody in the health care field accepts in its entirety and many reject in either principle or format, or both? (It was not that long ago that relative value scales were banished by the anti-trust minions.) Why have they made the rules for complying with their regulations more complex and complicated than the much maligned income tax forms? Why have they mandated major penalties for minor transgressions? Why, in the face of mounting pressure to cut health care costs, do they increase these costs by enlarging the size of the secretarial pools in offices and in hospitals in order to comply with their regulations? Can we believe Dr. Louis Sullivan, head of HHS, when he told Mr. David Brinkley and his panel that he would make a sincere effort to simplify the means of complying?

Most of the criticism has been based on an assumption that all parties have been acting in good faith. The government and its bureaucracy have been characterized as inept, too often swayed by economists instead of health care workers, too politically oriented, inefficient, uneducated, noneducable, and the like, but still acting, perhaps in a misguided way, for the benefit of the American people. Could the scenario be misconstrued? Are we, the professionals, the only ones acting in good faith, without hidden motive?

Do the Feds care that reducing



Howard D. Slobodien, MD

the already too-low fees to physicians may force many physicians out of the Medicare program and some physicians out of practice entirely? It has been postulated that this would reduce the availability of care to the Medicare patient, resulting in fewer encounters, both cognitive and procedural, over the same time span, thus helping to insure the budget-neutral health care plan so dear to Congress. (Some non-Medicare patients would be affected similarly.) But does not this constitute de facto rationing, much easier to cram down the throats of an unsuspecting population than legislation or regulation mandating the same? Dr. William Roper, then head of HCFA, and Mr. Paul Ginsburg, director of the Physician Payment Review Commission, indicated in 1987 the importance of controlling the volume of services in order to control costs of the "behavioral offsets" in today's world. But a reduction in the number of physicians in the program, by active or passive means, could have the effect of reducing patient treatments without the government having to appear as the ogre who is rationing care.

Does the government worry that hospitals have to cost shift to non-Medicare payers in order to maintain solvency? If cost shifting is reduced or disallowed, will hospitals close? If the proposed 1992 New Jersey State Health Plan is adopted, will it force some hospitals to close and some services to be merged? (The New Jersey State Department of Health [NJDOH] could have allowed inefficient hospitals to self-destruct years ago by abolishing certificates of need and allowing marketplace competition to prevail, with carefully planned taxpayer help for those hospitals giving nonreimbursed care. Instead NJDOH plans to increase the areas requiring certificates of need and to regulate everything—physicians' offices, hospitals, nursing homes, home health activities, mobile health services, laboratories, and all high-technology modalities. As expected, there is no substantive physician or Medical Society of New Jersey input.) When hospitals close, beds are reduced and services are not easily available, are we not seeing rationed care?

The American people are schizophrenic in their approach to health care. They want full coverage, but they will not pay for it. They want entitlement programs trimmed, but also want to be added to the list of those entitled. The American people want hospital beds and services curtailed, but not in their localities (the old "not in my backyard" syndrome). They want less governmental intrusion into their lives, but welcome more gov-

ernmental regulation of physicians. The American people want unlimited awards for noneconomic damages, but want lower fees to those who save lives and preserve health. They want physician assistants, nurse practitioners, and optometrists to prescribe and to treat, but they want physicians to be held accountable. In truth, the American people want to have their cakes and eat them, too.

It is obvious that the physician cannot be, or allowed to be, all things to all people. We are well past the time when we were semi-deified and our recommendations were like commandments. It is undoubtedly better to have mutual understanding between the patient and doctor, but a reasonable line has been crossed and we are even being deprived of what a blue collar workman deserves and gets—honest pay for honest work. How many bright, motivated, self-reliant, and resourceful college students considering career opportunities will continue to dismiss the practice of medicine as a viable option?

It is a travesty. The geriatric age group is the fastest-growing population segment, by far, yet the increasing needs of this group for more physicians and more patient visits are being denied by our government, systematically, inexorably and very, very quietly as to its true intent. □

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"The visigoths of Washington have raped and pillaged the medical profession and I am so damned angry I cannot see straight." Henry Mineur, 1991

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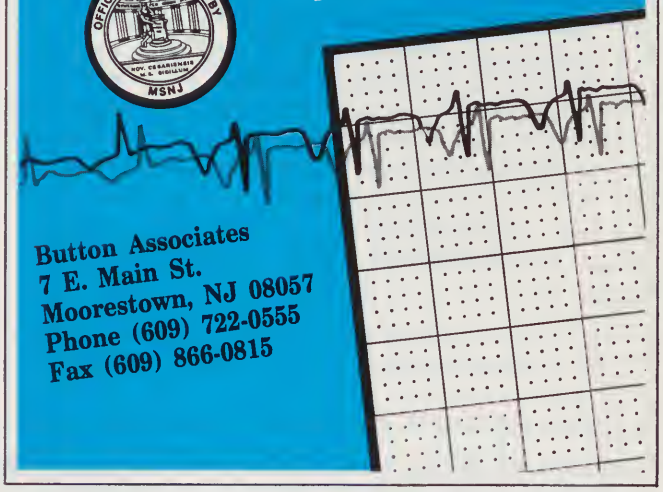
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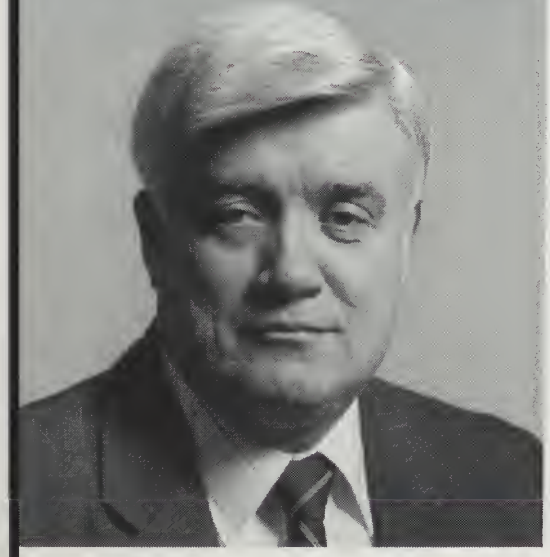
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Guest Editorial: Chronic Fatigue Syndrome

Monroe S. Karetzky, MD

Chronic fatigue is a common complaint in all industrial societies, occurring in 14 to 25 percent of the general population and in 24 percent of patients attending a primary care clinic.[1] Recently, in order to add perspective to chronic fatigue syndrome (CFS) as representing a real entity and to facilitate investigational efforts, a working group of the Centers for Disease Control (CDC) published formal standards for establishing the pathological nature of the syndrome.[2] This debilitating tiredness does not respond to bed rest, has not occurred previously, and reduces daily activity below 50 percent. Using the major and minor criteria, as shown in Table 1, less than 5 percent of patients of a specialized fatigue clinic and less than 1 in 10,000 persons in a general community population qualify for the diagnosis of CFS.[3]

CFS has long been postulated to be a postinfectious sequela, particularly of the Epstein-Barr virus (EBV), and has been described under several such related labels (Table 2). The postviral fatigue syndrome (PVS) has been considered a particular form of CFS occurring in clusters and sporadically. Subsequently, polyclonal activation of B cells became a common finding with antibodies to several viruses identified in patients as well as in normal subject's serum. These have included EBV as well as enteroviruses, retroviruses, and herpesviruses. In general, detailed studies have failed to find any consistent serologic evidence in controlled studies of an etiological association of CFS with any of the human viruses suggested.[4] Other studies have reported evidence of immunologic dysfunction reflecting both deficiency and immune activation.[5,6]

Neuropsychiatric complaints are commonplace. In patients with CFS, a diagnosis of depression is predominant although it still is being debated whether depression is secondary to CFS, whether depression precedes it, or whether depression and CFS have a simultaneous onset.[7] Myopathic findings also have been reported but lack confirmation of uniformity. The syndrome is associated with normal cardiac function but with limited exercise capacity characterized by relative exercise bradycardia.[8] A variety of techniques has been used documenting normal muscle strength, endurance, and recovery in these patients. Similarly repeated studies of muscle performance have shown minimal or no significant abnormality of

Table 1. ***Diagnostic criteria for chronic fatigue syndrome.***

I Major Criteria: Both must be present

1. Fatigue of new onset and of least six months' duration unrelieved by bed rest with greater than 50 percent reduction in activity
2. Other causes of symptoms have been eliminated

II Minor Criteria: At least 6 of 11 symptoms and 2 of 3 physical criteria, or at least 8 of symptom criteria

1. Physical Examination
   - A. Cervical or axillary lymphadenopathy
   - B. Low-grade fever
   - C. Pharyngitis
2. History
   - A. Generalized muscle weakness
   - B. Myalgia
   - C. Prolonged fatigue after moderate fatigue easily tolerated
   - D. Headaches different in character from those previously experienced
   - E. Migratory arthralgia
   - F. Sleep disorder: Hypersomnia or insomnia
   - G. Neuropsychological complaints (photophobia, scotoma, forgetfulness, irritability, confusion, difficulty thinking, difficulty concentrating, and depression)
   - H. Acute onset of symptom complex (hours to a few days)

Table 2. *Chronic fatigue syndrome (CFS).*

Postviral fatigue syndrome (PVS)

1. Chronic mononucleosis
2. Chronic mononucleosis-like syndrome
3. Chronic active Epstein-Barr virus (EBV) syndrome
4. Myalgic encephalomyelitis (ME)
5. Epidemic neuromyasthenia
6. Postinfectious neurasthenia
7. Iceland disease

muscle contractile force in patients with CFS. Evidence has not been found to support the thesis of poor motivation to be a factor, leading some investigators to conclude that the defect must lie in the central nervous system "above the level of the motor cortex."[9]

In summary, as a result of recent investigations, CFS has been designated an organic syndrome of unknown and possibly multifactorial etiologies. Critical appraisal has all but eliminated the earlier belief of EBV as the etiological agent and has concluded that associated depression is secondary to the disability and protracted fatigue. The immunologic findings also have been found to be highly variable and have not been shown to correlate with the severity or cause of the disease. Management consists of acknowledging the reality of the syndrome and support.

In the absence of a specific laboratory marker, the article in this issue of *NEW JERSEY MEDICINE* by Dr. Simpson (pages 211-216), though representing anecdotal case reports, is of interest. It is not by coincidence that hemoglobin is concentrated in biconcave packets of small size. Such a delivery system facilitates O_2 transport with a minimal blood viscosity for its Hb concentration and tissue vascular volume to fulfill the cellular oxygen demand. It does, however, create a critical dependence on the elasticity of the red blood cell membrane to allow relatively large cells to squeeze through narrow capillaries of smaller diameters. Such reversible deformation is hindered if the cells become deformed and their membranes lose their plasticity as suggested by the author. Alteration of blood fluidity by decreasing red cell deformability presents the potential of hemorrheological treatment for CFS with a drug such as pentoxifylline that has been shown to improve red cell deformability. If such findings are confirmed, the scientific basis for lack of oxygen, neuromuscular fatigue, and an intracellular anaerobic and acidotic environment in a targeted tissue region will have been established and a readily performed laboratory test available. This finding, of course, requires confirmation but presents yet another titilating mechanism for this devastating syndrome to be pursued in order to develop effective therapeutic management. ■

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Dr. Karetzky is a member of the Committee on Publication, Medical Society of New Jersey, and assistant director of medicine and director of pulmonary and critical care medicine, Newark Beth Israel Medical Center, 201 Lyons Avenue, Newark, NJ 07112.

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PRESIDENT 'S PAGE



AIDS—THE SECOND DECADE—WORKING TOGETHER!

As we enter the second decade of the AIDS pandemic, we are faced with a disease that is increasingly heterosexual, increasingly young, and increasingly female. By the year 2000, the number of women with AIDS—worldwide—will begin to equal that of men. In New Jersey, it is estimated that there may be 10,000 HIV-infected females, and a significant percentage acquired the disease by sexual intercourse. This is because HIV is approximately 12 times more likely to be transmitted from male to female than from female to male.

Indeed, we are just beginning to feel the impact of HIV/AIDS on women's health in New Jersey and in the United States. Some women do not even know they are infected until they deliver a seropositive infant. In 1988 and in 1991, an HIV serosurvey was performed on newborns in New Jersey. This survey revealed 0.5 percent of women delivering live babies in New Jersey were infected with HIV. In other words, more than 600 HIV-infected women deliver viable infants in New Jersey each year.

With the harsh reality of an increasing number of women of reproductive age becoming infected with HIV, it is imperative that the health care community implement innovative strategies for the early detection and clinical management of HIV-seropositive women.

With this knowledge, several organizations and agencies deliberated—separately and together—about this issue. In 1989, the New Jersey State Department of Health (NJDOH) recommended "that all women who are pregnant, or about to become pregnant, be tested for HIV." The Medical Society of New Jersey (MSNJ), the New Jersey Obstetrical and Gynecological Society, the New Jersey Section of the American College of Obstetricians and Gynecologists, and NJDOH reached the same conclusion. At a joint meeting in January, these organizations decided to contact every obstetrician/gynecologist in the state and urge them to "regularly offer counseling and testing of their pregnant patients, with the hope of making an early diagnosis in order to begin optional medical care."

Each New Jersey obstetrician/gynecologist soon will receive a letter and counseling instructions. As an obstetrician/gynecologist, I encourage and urge you to do all you can to work towards improving the recognition and treatment of HIV/AIDS, and I can assure you that all societies and agencies in New Jersey will continue to do the same.

I have asked NJDOH Commissioner Frances J. Dunston, MD, to add her comments:

In December 1989, NJDOH issued recommendations on HIV testing of pregnant women. These recommendations stated that all women of childbearing age be given HIV education, and that, as a standard of practice, all women who were pregnant or contemplating pregnancy be offered voluntary HIV testing.

In November 1991, I announced NJDOH's recommended testing policy: all sexually active persons seek testing for HIV. I specifically repeated the previous recommendation that all women who are pregnant or contemplating pregnancy should have HIV testing.

It is more imperative today than it was in 1989 that pregnant women be offered HIV testing. There now is medical management that can be offered to HIV-infected women and infants, management that probably can prolong the lives of many infected women and children. The evaluation, and occasionally treatment, of potentially HIV-infected infants should begin as early as one month of age; it is very important that such infants be identified early, preferably before birth.

HIV infection and AIDS have become one of the leading causes of death in New Jersey. I am asking that all members of MSNJ take an active role in fighting this disease by providing clear and accurate information concerning the risk factors for HIV infection to women, particularly those of childbearing age.

The standard practice for caring for women in New Jersey should include: universal education about HIV and its transmission; risk reduction counseling on drug use and sexual behavior; and a strong recommendation for voluntary HIV testing to all pregnant women or women contemplating pregnancy.

In addition, I ask again that you be alert to any clinical manifestations of HIV disease in your patients, particularly symptoms in women that were not as well known in the past. HIV testing should be recommended when there is any clinical suspicion of HIV infection.

NJDOH believes that, with the support and cooperation of the members of MSNJ, we can make progress in early identification, treatment, and prevention of HIV infection in New Jersey. □

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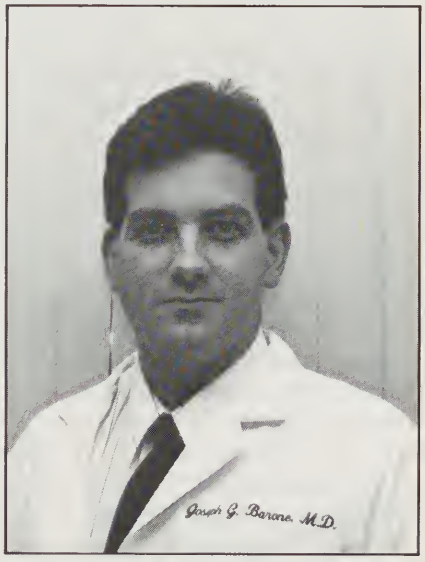
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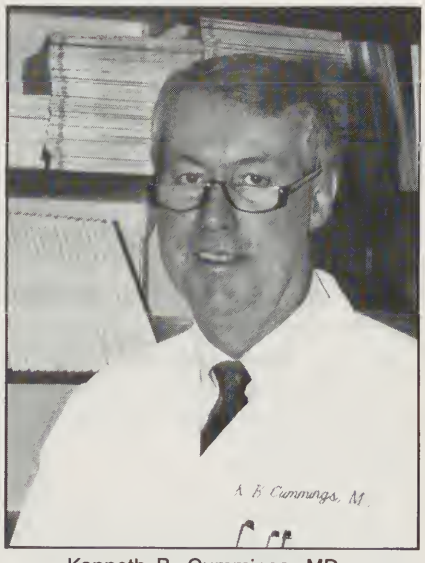
Writing Competition Winner: Robert Wood Johnson Pouch

Joseph G. Barone, MD
Kenneth B. Cummings, MD

Traditional treatment for muscle invasive bladder cancer requires the creation of an abdominal stoma for urinary diversion. The authors report a technique for orthotopic bladder substitution. This paper was the 1991 winner of the MSNJ Writing Competition.



Joseph G. Barone, MD



Kenneth B. Cummings, MD

Gilcrest used an ileocecal segment to replace the bladder in 1950, but high-pressure peristaltic waves caused dangerous intrarenal reflux, making the technique unacceptable.[1] In the 1960s, Kock discovered if the bowel segment was opened and then closed in the shape of a sphere, the peristaltic wave would be interrupted.[2] Since then, this principle of detubularization has been used to create low-pressure continent urinary reservoirs.

Though continent reservoirs are more attractive to patients than standard ileoconduits, they can be technically difficult to construct.[3] If orthotopic bladder substitution is desired, there is the additional problem of gaining enough mobility to allow the isolated intestinal segment and ureters to reach the pelvic floor.[4] This may not be possible if the mesentery of the reservoir is short, the pelvis is deep, or limited left ureteral length remains after cystoprostatectomy.[5]

In order to overcome mobility problems associated with orthotopic bladder substitution, we modified an ileocecal bladder to create a urinary reservoir that is easy to construct and has enough mobility to consistently reach the pelvic floor. We describe the surgical technique and the initial three cases that led to the development of the pouch.

METHODS AND MATERIALS

Three male patients, ages 55, 59, and 65 years, underwent cystoprostatectomy for muscle invasive bladder cancer. Intraoperatively, it was determined that traditional orthotopic bladders could not be used as one patient had a tethered right mesocolon from adhesions, and each of the other two patients had a deep pelvis and limited left ureteral length after surgery.

In an attempt to create a pouch with enough mobility to reach the pelvic floor, equal lengths of ileum and cecum were isolated on the ileocolic vascular pedicle (Figure 1A). The bowel segment was opened along its antimesenteric border (Figure 1B). The detubularized segment then was folded "like a book" and partially closed with running 2-0 polyglycolic acid suture (Figure 1C). The ureters were stented and implanted superiorly in the same anterior taenia using the Leadbetter anti-reflux anastomosis (Figure 1D). The base of the cecum was incised and anastomosed to the urethral stump over a 22F catheter (Figure 1E). The ureteral stents and a second 22F catheter were brought out of the pouch through the same incision.

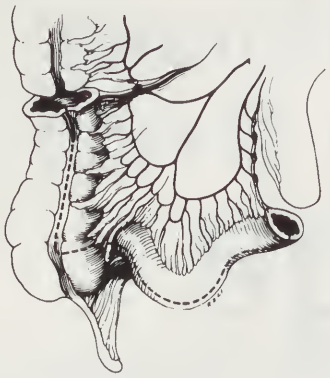


Figure 1A. Equal segments of ileum and cecum are isolated on the ileocolic vascular pedicle.

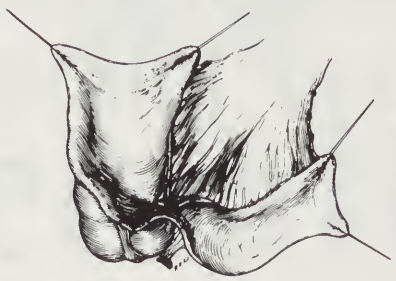


Figure 1B. The segment of cecum is opened along its antimesenteric border.

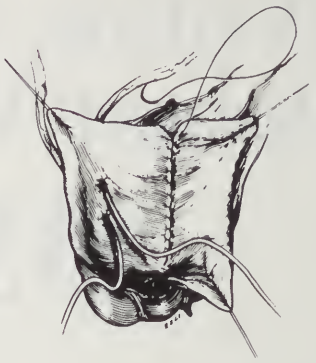


Figure 1C. The segment of ileum and cecum is folded like a book and partially closed.

The reservoir closure was completed with running 2-0 polyglycolic acid suture (Figure 1E).

RESULTS

All three male patients underwent this procedure. The average operating time was 45 to 60 minutes longer than ileoconduit, and no major complications occurred postoperatively. Ureteral stents were removed on day 10, and remaining catheters were removed on day 21. A voiding cystourethrogram, performed at 21 days, demonstrated the absence of reflux in all cases.

Three months after surgery, urodynamic evaluation showed maximum reservoir capacities ranged from 580 to 680 cc at pressures below 5 cm H_2O (Table). Uroflow rates ranged from 17 to 25 ml/sec and postvoid residuals were less than 75 cc. No peristaltic contractions were recorded in the reservoir. Serum sodium, potassium, chloride, bicarbonate, blood urea nitrogen, and creatinine remained normal for three months, postoperatively, and all patients are continent.

DISCUSSION

A urinary reservoir should be easy to construct and provide a low pressure, nonrefluxing storage chamber for urine.[5] The Kock and Mainz pouches have been used with considerable success.[2,6] Their design, however, is complex and the anti-reflux nipple has been reported to fail.[2,3] The Indiana pouch is easier to construct than the Kock or Mainz pouches and uses ileum, cecum, and ascending colon, including the hepatic flexure.[7] After the segment is detubularized, it is closed by folding the hepatic flexure down. Thus, the most superior part of the segment must be brought into the deep pelvis.[4] If the right mesocolon is tethered or the pelvis is deep, the hepatic flexure may not be able to reach the pelvic floor.[4] The Le Bag technique requires a 180° rotation of the ileocecal segment into the pelvis, which may not be possible if the mesentery is tethered from adhesions.[8] The ureters are implanted posteriorly or laterally in separate taenia making anastomosis difficult to perform if left ureteral length is limited after cystoprostatectomy. Ureteral obstruction also can occur depending on the angle of implantation. The Camey procedure is technically demanding and uses a long segment of detubularized ileum.[9] There is a significant risk of ureteral obstruction if the implantation angle is not precise.[4] In 15 percent of patients, the ileal mesentery is too short to reach the pelvic floor and vitamin B_{12} deficiency can occur since a long segment of ileum is defunctionalized.[9]

Our technique is simple and overcomes the problems associated with orthotopic bladders. The ileocolic artery provides excellent mobility because of its de-



Figure 1D. The ureters are stented and implanted superiorly in one anterior taenia using the Leadbetter technique.



Figure 1E. The base of the cecum is incised and anastomosed to the urethra over a catheter. The stents and a second catheter are brought out through the same incision in the pouch. Note the final anterior location of ureters.

pendent position. The more superior right colic artery and proximal ascending colon are excluded to avoid tethering. After the intestinal segment is isolated, it is detubularized, and closed "like a book" rather than "folding it down." This maintains the superior-inferior orientation of the reservoir and avoids having to bring the superior part of the intestinal segment into the deep pelvis. The ureters then are implanted superiorly in one anterior taenia. This technique is reliable and simple, and requires less left ureteral length than lateral placement. Also, since the implantation angle is nearly 180°, the risk of ureteral obstruction is minimized.

CONCLUSION

We believe the modification of the ileocecal bladder is useful for patients with a short right mesocolon, a deep pelvis, or limited left ureteral length. Some important technical points that increase pouch mobility include the following: excluding the right colic artery and ascending colon; folding the opened intestinal segment closed "like a book" rather than "folding it down"; and implanting the ureters superiorly in one anterior taenia. ■

Table. ***Urodynamic data.***

	Patient 1	Patient 2	Patient 3
VCUG	No reflux	No reflux	No reflux
Maximum volume	680 cc @	508 cc @	538 cc @
Pressure	2 cm H_2O	3 cm H_2O	2 cm H_2O
Uroflow	17 ml/sec	25 ml/sec	22 ml/sec
Postvoid	75 cc	50 cc	62 cc

Dr. Barone is a resident in urology, UMDNJ-Robert Wood Johnson Medical School, New Brunswick. Dr. Cummings is professor and chief, Division of Urology, UMDNJ-Robert Wood Johnson Medical School. Address reprint requests to Dr. Barone, UMDNJ-Robert Wood Johnson Medical School, CN 19, New Brunswick, NJ 08903-0019.

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Mycobacterium haemophilum Osteomyelitis in an AIDS Patient

Indu Gupta, MD
Jeffrey Kocher, MD
Anne J. Miller, MD
Steven J. Weisholtz, MD
John Perz, MS
Mary Scully, BS

Mycobacterium haemophilum *is a fastidious species that has been isolated from skin and subcutaneous nodules. The authors describe a case of* Mycobacterium haemophilum *osteomyelitis and skin infection in an AIDS patient and successful treatment with minocycline.*

Our patient was a 31-year-old woman diagnosed with human immunodeficiency virus (HIV) infection in February 1988, following a six-month history of recurrent vaginal candidiasis, fevers, and night sweats. She was treated with azidothymidine (AZT) for 15 months, then briefly with dideoxyinosine (DDI) that was discontinued due to peripheral neuropathy in August 1989. In December 1989, she developed severe pain and swelling of the left ankle. Three weeks later, there was radiographic evidence of osteomyelitis of the distal and mid tibia. At surgery, there was tenosynovitis and osteomyelitis. Specimens of the tibia showed acute suppurative inflammation with acid-fast bacilli (AFB) on Ziehl-Neelsen stain; however, cultures on Lowenstein-Jensen and Petragnani agar at 37° C were negative. Therapy for presumed *Mycobacterium tuberculosis* and *Mycobacterium avium intracellulare* was initiated with isoniazid, rifampin, ciprofloxacin, ethambutol, clofazimine, and amikacin.

Over the next three weeks, the patient developed multiple violaceous skin nodules of the extremities, tenosynovitis of the right index finger with spiking fevers, and weight loss. A large fluctuant mass in the buttock drained 100 cc of serosanguinous fluid. Biopsy of a skin nodule on the right arm revealed an intense polymorphonuclear panniculitis with myriad AFB organisms. A culture at 30° C on Lowenstein-Jensen media showed scant growth at eight weeks, but vigorous growth was found on chocolate agar at 30° C. The isolate was identified at the National Jewish Center for Immunology and Respiratory Medicine in Denver, Colorado, as *Mycobacterium haemophilum.* The culture demonstrated in vitro sensitivity to minocycline at 8 mcg/ml, but was resistant to isoniazid, rifampin, ethambutol, ethionamide, ciprofloxacin, streptomycin, amikacin, clofazimine, cycloserine, and cefoxitin.

The patient had progressive spread of new lesions and persistent fever despite eight weeks of the initial multidrug regimen. Following isolation of the acid-fast organisms at 30° C on chocolate agar, therapy was changed to minocycline 600 mg/day and rifampin 600 mg/day. There was rapid improvement on the new regimen with healing of skin lesions, resolution of fever, and weight gain. Many of the violaceous nodules had developed spontaneous suppurative drainage and all of these healed within six weeks of beginning minocycline. Pain and swelling of the left leg improved dramatically; after 18 months, the patient is fully ambulatory. Radiographs continue to show lucencies of the tibial shaft without significant change.

Liver chemistries were mildly elevated at presentation and progressively worsened during the first two months of illness. Prior to initiation of minocycline, the alkaline phosphatase was 386 IU (25-140), SGOT was 242 IU (0-40), SGPT was 250 IU (0-45), and GGTP was 560 IU (7-37). With the exception of GGTP, now 168 IU, the liver chemistries returned to normal following four months of minocycline and rifampin. Although blood cultures for mycobacteria were negative, it is our impression that the hepatic abnormalities reflected visceral dissemination.

DISCUSSION

Mycobacterium haemophilum is a recognized pathogen of humans. Since the original description by Sompolinsky, there have been 18 reported cases from Australia, Israel, Canada, and the United States.[4] The majority of patients were renal transplant recipients or persons with lymphoma. Four patients had acquired immunodeficiency syndrome (AIDS) due to HIV infection,[1-3] and two patients

were healthy children with lymphadenitis.[3,5] The Centers for Disease Control (CDC) is investigating approximately 12 new cases of probable *Mycobacterium haemophilum* infection in AIDS patients within the metropolitan New York area.

Most patients have presented with violaceous subcutaneous nodules on the extremities. Tenosynovitis and joint involvement occurred in three patients.[2,6,7] Osteomyelitis due to this organism has been reported in one patient.[7] The apparent rarity of *Mycobacterium haemophilum* infection may be due to its fastidious growth requirements. Isolation is best at 30° C to 32° C and the organism does not generally grow well at 37° C.[6,8] Growth is brisk on media containing lysed red blood cells, but artificial media must be supplemented with hemin, hemoglobin, or ferric ammonium citrate.[9] There may be a prolonged incubation time for primary isolation from clinical material.

Previously reported isolates generally have demonstrated in vitro resistance to isoniazid, ethambutol, PAS, and streptomycin. Several reported isolates have been susceptible to rifampin; however, there is a lack of standardized in vitro testing methodology making it difficult to draw conclusions about the clinical relevance of these results.

Despite treatment with rifampin-containing regimens, three AIDS patients failed to improve. Information on minocycline sensitivity is available for only one of the previous clinical isolates.[10] This patient had a combined infection with *Mycobacterium haemophilum* and *Mycobacterium xenopi* and improved when treated with minocycline and surgical drainage. Followup testing of our patient with *Mycobacterium haemophilum* showed in vitro sensitivity to clarithromycin, azithromycin, and thiacetazone.

Mycobacterium haemophilum should be suspected in patients with impaired T cell immunity presenting with chronic cutaneous and skeletal infection. The optimal treatment is unknown, but empiric therapy with a regimen containing minocycline should be considered. The macrolide antibiotics, azithromycin and clarithromycin, may have a role in the treatment of this highly resistant mycobacterial species. ■

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The authors are affiliated with Englewood Hospital: Dr. Gupta is a resident, Department of Internal Medicine; Drs. Kocher and Weisholtz are attendings, Department of Infectious Disease; Dr. Miller is an orthopedic surgeon; Mr. Perz and Ms. Scully are supervisors, Department of Microbiology.

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Pulmonary Complications of Acute Myelogenous Leukemia

Timothy O'Donnell, DO
Monroe S. Karetzky, MD
Julian Decter, MD

Pulmonary complications of acute myelogenous leukemia are attributed to infection, hemorrhage, or toxicity from chemotherapeutic agents. Rarely, damaged leukemic blast cells in lung parenchyma result in chest x-ray abnormalities and respiratory symptoms.

There are many causes of pulmonary infiltrates in leukemic patients. The autopsy incidence of pleural or pulmonary involvement in acute myelogenous leukemia (AML) ranges from 20 to 35 percent;[1-3] one series cited 64 percent.[4] Most parenchymal abnormalities are attributed to infection, hemorrhage, or pulmonary toxicity secondary to chemotherapeutic agents.[5]

Tryka described leukemic cell lysis pneumonopathy (LCLP), where leukemic blast cells presumably damaged by chemotherapy-released cytokines and other inflammatory mediators.[6] The patients had characteristic radiologic abnormalities, fever, and dyspnea.

The recognition of this noninfectious entity causing inflammatory parenchymal disease, pneumonopathy, requires clinical differentiation from infectious pneumonia, which is responsible for the majority of pulmonary infiltrates in leukemic patients and is the primary cause of death.[7]

Our patient developed a similar clinical picture, with parenchymal nodular infiltrates following induction chemotherapy that cleared spontaneously.

CASE REPORT

A 52-year-old white male presented with extreme fatigue and chest pain on exertion. A complete blood count revealed a hemoglobin concentration of 5 gm/dl and a white blood count (WBC) of 60,000/ml. Following the diagnosis of acute leukemia, the patient received induction chemotherapy with cytosine arabinoside (AraC) and mitoxantrone (Novantrone®).[8-9] The hospital course was complicated by neutropenia and fever, treated empirically with broad-spectrum antibiotics. There were no pulmonary symptoms and the chest x-ray remained negative. One blood culture subsequently was positive for *Candida* species. As the patient already had improved, it was decided not to treat with an antifungal agent and the patient was discharged. The patient was electively readmitted 10 days later, still asymptomatic, for placement of a chronic venous access catheter (Hickman®) to facilitate chemotherapy. The admission chest x-ray, however, revealed bilateral pulmonary nodules, diffuse in distribution (Figure 1). This was confirmed on computed tomography (CT) scan of the chest (Figure 2). The patient was afebrile with normal vital signs. The lungs were normal on auscultation. A small area of cellulitis, present on the left forearm, since the previous admission, showed improvement. The WBC was 18,000/ml; other laboratory values were within normal limits. The most recent chest x-ray available for comparison, performed nine days prior to his first hospital discharge while the patient was neutropenic, showed no nodules.

Routine aerobic and anaerobic bacterial, acid-fast bacilli, and fungal cultures of bronchoalveolar lavage (BAL) samples were negative. Cytological examination, including flow cytometry, failed to demonstrate any leukemic cells. A gallium scan was negative and the patient was treated with a second course of chemotherapy. The hospital course was uncomplicated and the patient was discharged. A chest x-ray ten days later, as well as a repeat CT scan, showed clearing of the lung fields (Figure 3).

DISCUSSION

Few patients with hematological malignancy survive hospitalization following open lung biopsy for evaluation of pulmonary infiltrates.[10,11] Therefore, it is important to be aware of leukemic cell pneumonopathy in order to evaluate the probability of infection as the cause of a new pulmonary infiltrate. Most studies of pulmonary infiltrates in leukemia



Figure 1. Chest x-ray showing bilateral pulmonary nodules and venous access catheter in place.

have included heterogenous groups of patients. The studies involved different underlying diseases, various immunosuppressive drug regimens, and allogenic bone marrow transplantation. Leukemic infiltration occurs primarily in a focal distribution at three sites in the lung: alveolar septum, nonparenchymal locations including peribronchial or perivascular collections, and subpleural infiltration.[3] This involvement usually is apparent only microscopically, and clinically and radiographically is silent. In determining specific infection etiologies for pulmonary infiltrates, transbronchial biopsy and open lung biopsy can be diagnostically misleading in patients with acute leukemia.[10] The use of BAL, moreover, in patients with acute leukemia, treated with antineoplastic agents, is not useful in detecting causative pathogens of pneumonia.[12] This is in contrast to the favorable reports in more severely immunocompromised patients such as those having had bone marrow transplants where *Pneumocystis carinii* and cytomegalovirus pneumonia are common.[12] The findings at autopsy in patients with acute leukemia where these and other viral pneumonias are uncommon show infiltrates attributable to *Candida,* aspergillus, or nonspecific pneumonia, further supporting the arguments for empiric therapy.[13-15] Autopsy examination is the only definitive diagnostic procedure and even then a significant number of patients will have a nonspecific diagnosis of interstitial pneumonitis.[10] It has been shown repeatedly that, despite residual leukemia at autopsy, pulmonary parenchymal involvement by leukemia cells is rare.[1,12]

Tryka suggested his findings[6] were similar to the nonspecific pneumonias frequently seen in patients with hematologic malignancies after chemotherapy.[5,10] He attributed the response of diffuse alveolar damage (DAD) to release of intracellular chemical mediators or metabolic products of lysed blast cells rather than simple leukostasis. His patients had patchy alveolar or nodular bilateral infiltrates on chest x-ray and fever, as did our patient. The distribution of the lesions suggested a uniquely limited release of soluble mediators with successful localization of the injury to lung parenchymal cells. His patients had biopsies performed on the average of 23 days after the introduction of chemotherapy. The chest x-rays began to resolve from 3 to 17 days postbiopsy in four patients. The remaining patient had only partial clearing of the chest x-ray with remnant scarring.

The followup chest x-ray on our patient, taken 19 days after the start of chemotherapy, demonstrated complete clearing.

Vascular occlusion by leukemic cells is rare. In contrast to diffuse pulmonary involvement, vascular occlusion correlates with the peripheral WBC[3,16,17] and can result in infarction.[1] Tumor cell emboli and leukostasis with vascular obstruction in the absence of x-ray findings have been reported in autopsy studies of acute leukemia.[1,16] Rapid and even fatal pulmonary edema was reported initially in acute leukemia[3] without considering sequestration of WBC or leukostasis that could initiate nonspecific mechanisms of pulmonary damage as a result of WBC activation, such as seen in leukoagglutinin transfusion reactions[18] and the numerous other conditions predisposing to acute lung injury (adult respiratory distress syndrome). Others have reported respiratory distress due to intravascular leukostasis in a hyperleukocytic phase of AML requiring emergency chemotherapy with dramatic regression of symptoms in parallel to the fall in the peripheral WBC.[3,19] At autopsy, vascular leukostasis in the lung was the predominant finding without parenchymal infiltration.

Malignant cells have been ob-

tained by BAL in patients with pulmonary lymphomas[20-23] and acute myelomonocytic leukemia[24] with infiltrates on chest x-ray. Cytopathologic and immunologic analyses of the lavage fluid in lymphoproliferative processes and cytochemical studies in myeloproliferative disorders allow for the differentiation of benign from malignant cells.[22-24] Flow cytometry was performed on the BAL fluid obtained from our patient, but no leukemic cells were identified.

Marsh reported a patient with acute myelomonocytic leukemia, with an admission WBC of 14,200/ml with 8 percent blasts.[25] This patient received three courses of chemotherapy for recurrent osteoarticular symptoms and blasts over a ten-week period; the patient expired in respiratory failure during week ten. Ten days prior to death, she developed persistent bilateral interstitial infiltrates on the chest x-ray accompanied by progressive respiratory failure. At autopsy, leukemic blasts had diffusely infiltrated the alveolar septa. However, there was no mention of degenerated blasts cells.

Another report described a patient with an initially normal chest x-ray, who received remission induction chemotherapy. The patient developed cough, dyspnea, diffuse bilateral interstitial opacities, and low-grade fever with a rapidly falling WBC after 72 hours. An open lung biopsy revealed necrotic leukemic blasts. The infiltrates cleared spontaneously.[26]

Although our patient did not undergo open lung biopsy or transbronchial biopsy, cytolysis pneumonopathy is the most likely diagnosis. The chemotherapy agents received do not classically cause pulmonary toxicity and, for cytosine arabinoside, the pulmonary complication is an extensive diffuse noncardiogenic pulmonary edema.[9,27,28] This pulmonary toxicity recurs with repeated drug administration and is not related to apparent tumor



Figure 2. CT scan of chest confirming presence of pulmonary nodular infiltrates bilaterally.



Figure 3. Chest x-ray showing clearing of the bilateral pulmonary nodules.

load,[29] but does appear to be dose related.[30] The patient was asymptomatic and afebrile and all routine, fungal, and mycobacterial cultures were negative after six weeks. The absence of leukemic cells in the fluid from BAL had an unknown negative predictive value since leukemic cells usually are not found in alveolar spaces[3] and leukemic infiltration, therefore, cannot be ruled out without transbronchial[31] or open lung biopsy. In the previous report of LCLP, sputum smears and cultures did not reveal any infectious agents and there was no mention of BAL being performed prior to lung biopsy.[6]

There are no other reports of degenerated leukemic blasts cells being found on BAL. All of the patients reported by Tryka were febrile and leukopenic; two patients were dyspneic following chemotherapy, as was our patient.[6]

We suggest that LCLP be considered with the abrupt appearance of nodular infiltrates following chemotherapy, but as a diagnosis of exclusion when all microbiological cultures are negative, and when leukemic cells are not found on invasive study, bronchoscopy, and bronchoalveolar lavage. Furthermore, we strongly support initial empiric antibiotic therapy as a clinical trial. ■

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Drs. O'Donnell, Karetzky, and Decter are affiliated with Newark Beth Israel Medical Center, Newark.

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Address reprints requests to Dr. Karetzky, Newark Beth Israel Medical Center, 201 Lyons Avenue, Newark, NJ 07112.



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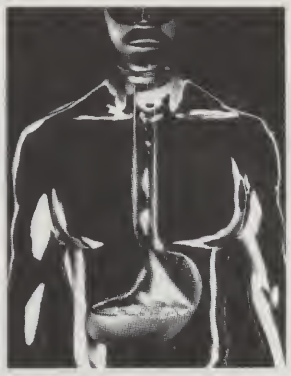
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Carcinogenesis, Mutagenesis, Impairment of Fertility– A 2-year oral carcinogenicity study in rats with doses as high as 500 mg/kg/day (about 80 times the recommended daily therapeutic dose) showed no evidence of a carcinogenic effect. There was a dose-related increase in the density of enterochromaffin-like (ECL) cells in the gastric oxyntic mucosa. In a 2-year study in mice, there was no evidence of a carcinogenic effect in male mice, although hyperplastic nodules of the liver were increased in the high-dose males as compared with placebo. Female mice given the high dose of Axid (2,000 mg/kg/day, about 330 times the human dose) showed marginally statistically significant increases in hepatic carcinoma and hepatic nodular hyperplasia with no numerical increase seen in any of the other dose groups.The rate of hepatic carcinoma in the high-dose animals was within the historical control limits seen for the strain of mice used. The female mice were given a dose larger than the maximum tolerated dose, as indicated by excessive (30%) weight decrement as compared with concurrent controls and evidence of mild liver injury (transaminase elevations). The occurrence of a marginal finding at high dose only in animals given an excessive and somewhat hepatotoxic dose, with no evidence of a carcinogenic effect in rats, male mice, and female mice (given up to 360 mg/kg/day, about 60 times the human dose), and a negative mutagenicity battery are not considered evidence of a carcinogenic potential for Axid.

Axid was not mutagenic in a battery of tests performed to evaluate its potential genetic toxicity, including bacterial mutation tests, unscheduled DNA synthesis, sister chromatid exchange, mouse lymphoma assay, chromosome aberration tests, and a micronucleus test.

In a 2-generation, perinatal and postnatal fertility study in rats, doses of nizatidine up to 650 mg/kg/day produced no adverse effects on the reproductive performance of parental animals or their progeny.

Pregnancy – Teratogenic Effects – Pregnancy Category C – Oral reproduction studies in rats at doses up to 300 times the human dose and in Dutch Belted rabbits at doses up to 55 times the human dose revealed no evidence of impaired fertility or teratogenic effect; but, at a dose equivalent to 300 times the human dose, treated rabbits had abortions, decreased number of live fetuses, and depressed fetal weights. On intravenous administration to pregnant New Zealand White rabbits, nizatidine at 20 mg/kg produced cardiac enlargement, coarctation of the aortic arch, and cutaneous edema in 1 fetus, and at 50 mg/kg, it produced ventricular anomaly, distended abdomen, spina bifida, hydrocephaly, and enlarged heart in 1 fetus. There are, however, no adequate and well-controlled studies in pregnant women. It is also not known whether nizatidine can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Nizatidine should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers– Studies in lactating women have shown that 0.1% of an oral dose is secreted in human milk in proportion to plasma concentrations. Because of growth depression in pups reared by treated lactating rats, a decision should be made whether to discontinue nursing or the drug, taking into account the importance of the drug to the mother.

Pediatric Use– Safety and effectiveness in children have not been established.

Use in Elderly Patients– Healing rates in elderly patients were similar to those in younger age groups as were the rates of adverse events and laboratory test abnormalities. Age alone may not be an important factor in the disposition of nizatidine. Elderly patients may have reduced renal function.

Adverse Reactions: Worldwide, controlled clinical trials included over 6,000 patients given nizatidine in studies of varying durations. Placebo-controlled trials in the United States and Canada included over 2,600 patients given nizatidine and over 1,700 given placebo. Among the adverse events in these placebo-controlled trials, only anemia (0.2% vs 0%) and urticaria (0.5% vs 0.1%) were significantly more common in the nizatidine group. Of the adverse events that occurred at a frequency of 1% or more, there was no statistically significant difference between Axid and placebo in the incidence of any of these events (see package insert for complete information).

A variety of less common events were also reported; it was not possible to determine whether these were caused by nizatidine.

Hepatic– Hepatocellular injury (elevated liver enzyme tests or alkaline phosphatase) possibly or probably related to nizatidine occurred in some patients. In some cases, there was marked elevation (>500 IU/L) in SGOT or SGPT and, in a single instance, SGPT was >2,000 IU/L. The incidence of elevated liver enzymes overall and elevations of up to 3 times the upper limit of normal, however, did not significantly differ from that in placebo patients. All abnormalities were reversible after discontinuation of Axid. Since market introduction, hepatitis and jaundice have been reported. Rare cases of cholestatic or mixed hepatocellular and cholestatic injury with jaundice have been reported with reversal of the abnormalities after discontinuation of Axid.

Cardiovascular– In clinical pharmacology studies, short episodes of asymptomatic ventricular tachycardia occurred in 2 individuals administered Axid and in 3 untreated subjects.

CNS– Rare cases of reversible mental confusion have been reported.

Endocrine– Clinical pharmacology studies and controlled clinical trials showed no evidence of anti-androgenic activity due to nizatidine. Impotence and decreased libido were reported with similar frequency by patients on nizatidine and those on placebo. Gynecomastia has been reported rarely.

Hematologic– Anemia was reported significantly more frequently in nizatidine than in placebo-treated patients. Fatal thrombocytopenia was reported in a patient treated with nizatidine and another H_2-receptor antagonist. This patient had previously experienced thrombocytopenia while taking other drugs. Rare cases of thrombocytopenic purpura have been reported.

Integumental– Urticaria was reported significantly more frequently in nizatidine- than in placebo-treated patients. Rash and exfoliative dermatitis were also reported.

Hypersensitivity– As with other H_2-receptor antagonists, rare cases of anaphylaxis following nizatidine administration have been reported. Rare episodes of hypersensitivity reactions (eg, bronchospasm, laryngeal edema, rash, and eosinophilia) have been reported.

Other– Hyperuricemia unassociated with gout or nephrolithiasis was reported. Eosinophilia, fever, and nausea related to nizatidine have been reported.

Overdosage: Overdoses of Axid have been reported rarely. If overdosage occurs, activated charcoal, emesis, or lavage should be considered along with clinical monitoring and supportive therapy. The ability of hemodialysis to remove nizatidine from the body has not been conclusively demonstrated; however, due to its large volume of distribution, nizatidine is not expected to be efficiently removed from the body by this method.

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Chronic Tiredness and Idiopathic Chronic Fatigue—A Connection?

Leslie O. Simpson, PhD

Evidence is adduced to support the proposal that pathological fatigue is a consequence of impaired capillary blood flow resulting in inadequate oxygen delivery, which is in accordance with physiological concepts of fatigue. Case reports are presented.

Van Amberg introduced the concept of idiopathic chronic fatigue and drew attention to the pervasiveness of fatigue as a medical problem.[1-3] In view of the wide range of conditions associated with fatigue, he proposed and defined "pathological fatigue" as a specific entity and concluded that because its cause is unknown and it is of long duration, idiopathic chronic fatigue is pathological.

It seems reasonable to regard modern medical entities such as chronic fatigue syndrome (CFS), postviral fatigue syndrome (PVFS), chronic fatigue and immunodeficiency syndrome (CFIDS), myalgic encephalomyelitis (ME), and nonspecific chronic tiredness as manifestations of pathological fatigue of unknown origin, i.e. of idiopathic chronic fatigue.

A major problem for patients and physicians is the absence of positive laboratory tests that could indicate the existence of an abnormal condition. In many cases, physicians' responses to negative tests are dismissive, i.e. a referral for psychiatric assessment or the statement, "There is nothing wrong with you."[4]

It could be argued that after negative laboratory tests, it is appropriate to refer patients for a psychological/psychiatric opinion, but the key factor concerns the nature of the negative tests. Clearly, routine laboratory tests would be inappropriate and the results unhelpful if the symptoms of tiredness and fatigue are due to the adverse effects of shape-changed red cells on capillary blood flow and oxygen delivery.

In attempting to understand how and in what way fatigue develops in its multiple settings, two basic possibilities can be recognized. There may be multiple forms of fatigue, each with its own etiology and pathogenesis or fatigue may have multiple etiologies but only a single pathogenesis. Van Amberg wrote, "These medical, surgical, obstetrical, traumatic, and psychiatric fatigues may be proved to have a common pathophysiology."[1] This possibility will be considered on the basis that impaired capillary blood flow with an associated inadequacy of oxygen delivery could be the common pathophysiological factor. While the postulated mechanism may be unique, the role of oxygen insufficiency in the development of fatigue was noted more than 30 years ago. French wrote, "There is no doubt that oxygen lack is the first cause of tissue cell exhaustion, which is manifested early as clinical tiredness."[5]

CHRONIC FATIGUE CAUSES

The literature on chronic fatigue is dominated by publications containing conflicting opinions over most aspects of the topic with a resulting dearth of helpful information for those who suffer from oppressive tiredness. An analysis of published work reveals three major types of investigators: virologists, immunologists, and behavioral scientists.

Virologists consider PVFS exists, while others propose that the fatigue is due to a persistent viral infection although viral antibodies are not detectable in many cases. Because of the tiredness associated with infective mononucleosis, Epstein-Barr virus was an early suspect.[6] More recently, enterovirus RNA has been demonstrated in skeletal muscle from some patients with PVFS.[7] It was noted that other viruses also would induce the syndrome. Patients in a California study who had a diagnosis of CFS have been shown to have gene sequences of a retrovirus in their white cell chromosomes[8] while some Boston patients with CFS had human herpesvirus reactivated during culture of peripheral blood monocytes.[9] Because the intracellular virus appears to be inactive, such findings are of little

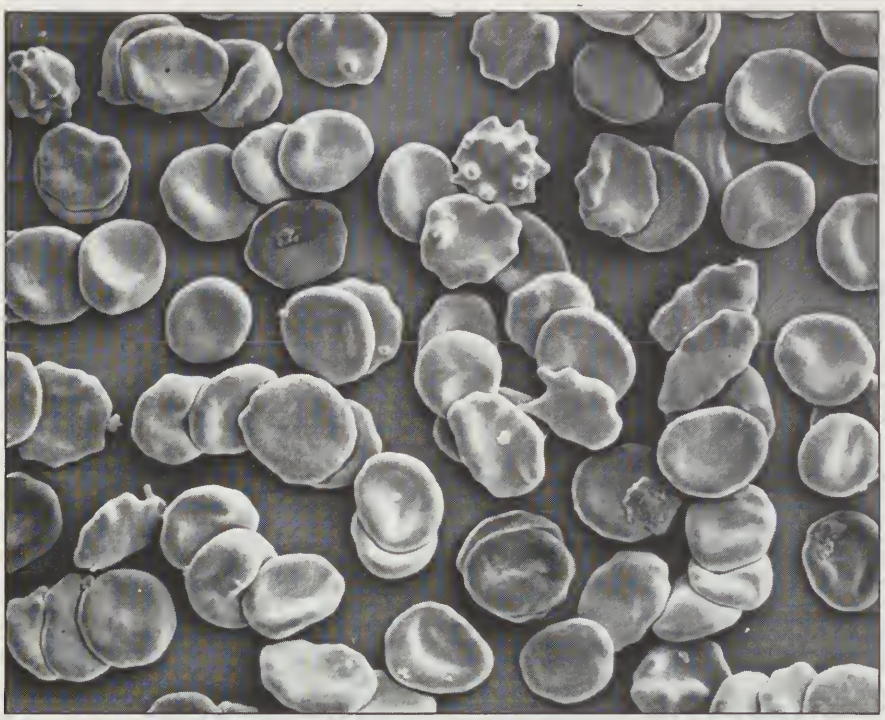


Figure 1. A micrograph of randomly associated erythrocytes from a 68-year-old woman with a complaint of long-term chronic tiredness. Five blood samples collected over a six-month period showed that the crenated cells (cells with altered margins) persisted throughout that time, although with some degree of variability. Red cell shape analysis results are: discoid cells, 26.1 percent; cells with surface changes, 20.2 percent; cup forms, 9.9 percent; and cells with altered margins, 43.6 percent. Original magnification was 2000 x.

help in explaining the relationship of the viral material to the occurrence of fatigue and labile symptoms. Furthermore, a placebo-controlled trial of the antiviral agent, acyclovir, failed to produce evidence of consistent benefit.[10]

Immunologists have reported changes in some subsets of T lymphocytes. Although the pathophysiological relationship between T cell numbers and the symptoms of fatigue and easy exhaustability are obscure, the concept of a chronic fatigue and immunodeficiency syndrome has gained restricted support.

Behavioral scientists have put forward several proposals to support their claim that chronic fatigue has a behavioral basis. They point to the well-recognized association of fatigue and depression; they claim that "central fatigue" is involved, with muscle function being impaired because of inappropriate signals from the brain; they can point to the success obtained with the use of antidepressive therapy.

The problem in attempting to combine the findings from the three disciplines concerns the composition of the various study panels and the impossibility of deciding whether or not all the different patients involved did suffer from the same disorder. While criteria for a diagnosis of CFS have been formulated by the Centers for Disease Control,[11] Manu stated that the criteria excluded many subjects with a complaint of chronic tiredness.[12] While researchers in the three disciplines have reported a variety of findings, none have provided a basis for understanding the mechanism of chronic fatigue and its associated plethora of symptoms.

PHYSIOLOGICAL ASPECTS/ CAPILLARY BLOOD FLOW

It is axiomatic that normal tissue function requires normal capillary blood flow for the delivery of oxygen and metabolic substrates and the removal of metabolic wastes. During muscular activity, there is an increased demand for oxygen and metabolic substrates that is met by increasing the rate of capilliary blood flow. It is postulated that impaired capillary blood flow could be a key factor in the development of muscle fatigue because of its adverse effect on oxygen delivery. This proposal is in accord with the opinions of physiologists. For example, Griffiths noted that muscle fatigue probably was due to oxygen deficiency and the effects of localized accumulations of metabolites, including lactic acid, when the metabolites were not removed because of impaired capillary blood flow.[13] Another source noted that physical fatigue after prolonged activity was the result of depletion of energy stores and an accumulation of lactic acid termed the "fatigue substance."[14] Reduced performance capacity was a result of the combined effects of localized acidosis and depletion of energy stores.

According to Wiles, energy generation may fail if there is an enzymatic block in the glycogenolytic pathway or if there is a failure of oxidative metabolism.[15] Wiles considered the limiting features of energy generation to be blood flow; oxygen delivery (that depends upon the former when hemoglobin concentrations are normal); and the nature of the dominant metabolic pathway in use. It was emphasized that glycogenolysis and oxidative metabolism are not alternatives. Although glycogenolysis may be predominant when oxidative metabolism is not possible because of inadequate availability of oxygen, it is inappropriate for activity of long duration because of the limited amounts of stored glycogen, the lower energy output, and the production of lactic acid. Erythrocytes incubated in physiological concentrations of lactic acid became less filtrable.[16] This observation raises the possibility that localized accumulations of lactic acid could make

erythrocytes less deformable and, thus, impair capillary blood flow.

These comments by physiologists on the importance of capillary blood flow in normal muscle function and the role of inadequate oxygen delivery in the development of muscle fatigue highlight the possibility that impaired capillary blood flow is an essential element in the mechanism of chronic fatigue. Furthermore, after the depletion of intracellular energy stores, impaired capillary blood flow would hamper the restitution of intracellular energy stores. This could explain the co-occurrence of fatigue and an early onset of exhaustion during exertion.

RED CELL SHAPE, CAPILLARY BLOOD FLOW, AND OXYGEN DELIVERY

Normal erythrocytes are able to pass through capillaries much smaller than the cell diameter because of their capacity to change shape. This facility of deformability is due to the "spare" cell membrane that lines the concavities of biconcave discocytes. The ability of a cell to undergo deformation is lessened when the "spare" membrane is reduced or absent as in nondiscocytic cells. In contrast to the generally accepted belief that all erythrocytes are biconcave discs, peripheral blood from healthy animals and human beings contains six different shape classes of erythrocytes.[17] Chronic diseases have been found to be associated with different patterns of change in the proportions of the shape-determined classes of nondiscocytic cells[18-20] and unpublished observations. Increased proportions of nondiscocytic cells have been shown to reduce the rate of capillary blood flow with a commensurate reduction in the rate of oxygen and substrate delivery.[21,22] Echinocytic transformation of red cells resulted in a 45 percent reduction in oxygen uptake and a 23 percent decrease in oxygen release rate.[23] Kon reported that in conditions with low flow velocity, deoxygenation of echinocyte-transformed erythrocytes was retarded, possibly because of an increased thickness of the stagnant layer around the cells.[24]

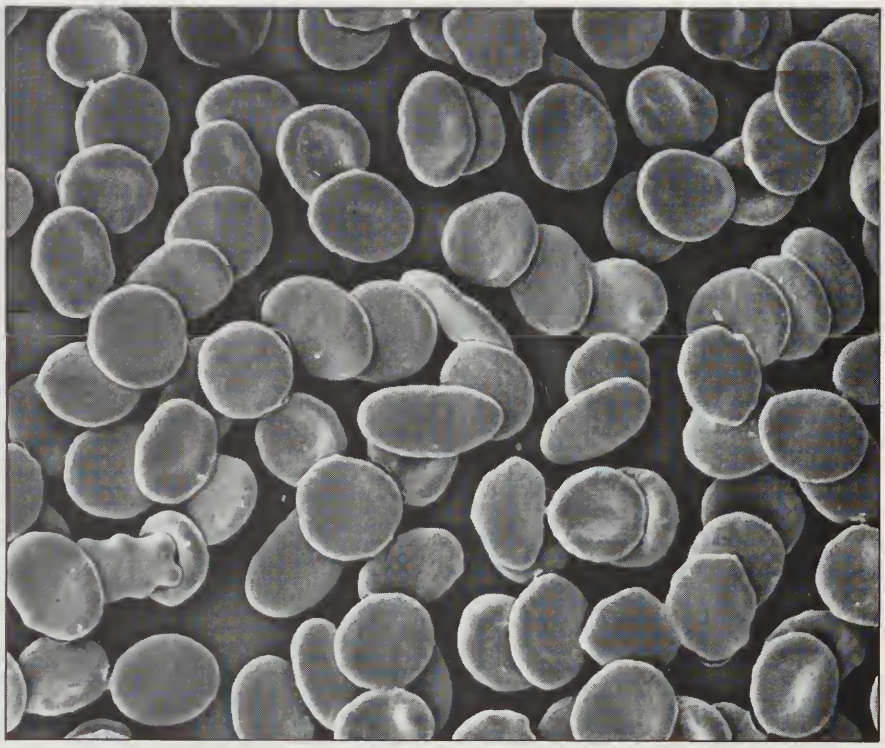


Figure 2A. A sample taken when a 38-year old woman was feeling well. Red cell shape analysis results are: discoid cells, 87.8 percent; cells with surface changes, 4.7 percent; cup forms, 0.6 percent; and cells with altered margins, 6.9 percent.

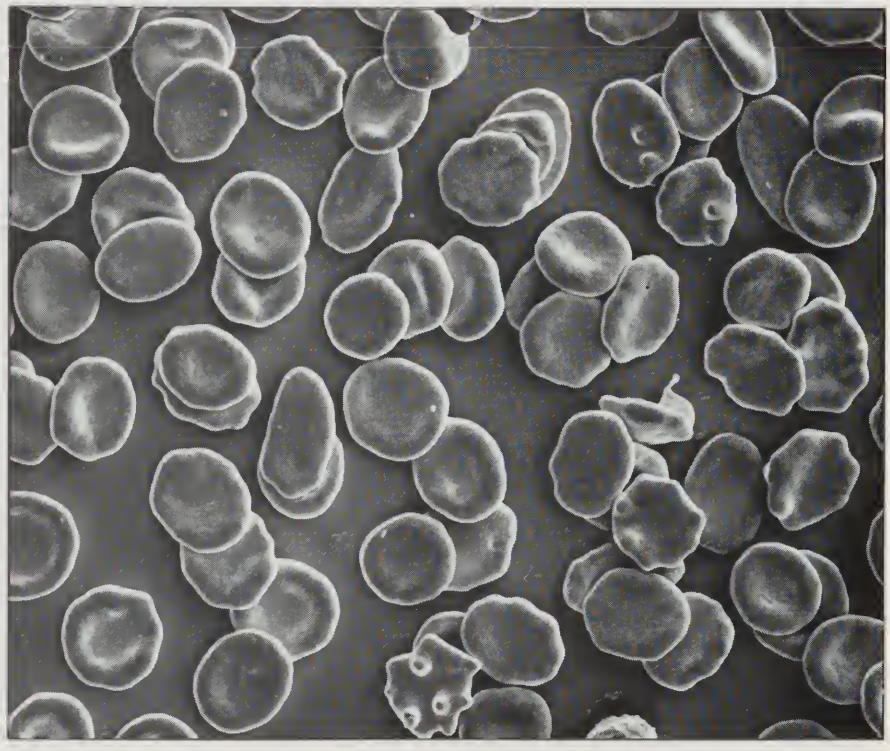


Figure 2B. A sample taken when a 38-year-old woman was lethargic and suffering from a severe, early morning headache. Red cell shape analysis results are: discoid cells, 55.6 percent; cells with surface changes, 7.0 percent; cup forms, 0.0 percent; and cells with altered margins, 37.3 percent. Original magnification was 2000 x.

Thus, there is experimental

evidence that links the effects of nondiscocytic cells to impairment of capillary blood flow and, therefore, to reduced oxygen delivery, and also raises the possibility that high proportions of echinocyte-transformed erythrocytes could be associated with a generalized tissue hypoxia. At present, there are no reports of in vivo studies on the effects of other types of nondiscocytic cells on capillary blood flow and oxygen delivery.

CHRONIC TIREDNESS/ IDIOPATHIC CHRONIC FATIGUE AND RED CELL SHAPE

It had been observed that many patients with the complaint of long-term chronic tiredness had high percentages of crenated cells and early echinocytes in their peripheral blood. Such cases may be exemplified by the findings in the blood of a 68-year-old woman whose tiredness had persisted for more than 20 years while under regular medical care. A micrograph of her peripheral blood cells is shown in Figure 1 and red cell shape analysis indicated that more than 40 percent of her red cells were crenated. As even moderate exertion worsened her symptoms, this woman's condition would meet the criteria for Van Amberg's pathological fatigue[1] and prior to the finding of altered red cell morphology would have justified a diagnosis of idiopathic chronic fatigue. Even higher percentages of crenated cells were observed in the blood of two healthy and asymptomatic men and the possible existence of a crenated cell syndrome has been raised.[25] The apparent discrepancy between the symptoms produced in the woman and their absence in the men can be explained in terms of capillary diameter. In the case of the men whose altered red cell morphology was not accompanied by indications of impaired capillary blood flow, it is assumed that the capillary diameters were larger-than-usual, i.e. that the mean capillary diameter would fall in the upper quartile of a size distribution. In contrast, it is suggested that subjects with the symptoms of tiredness and high percentages of nondiscocytic cells in their blood, would have smaller-than-usual capillaries, i.e. those with mean capillary diameter falling in the first quartile of a size distribution. Subjects with this characteristic would always be at risk of red cell shape-related impairment of capillary blood flow. Because of the difficulties involved in assessing capillary dimensions, it is emphasized that data from red cell shape analysis should not be used in a predictive fashion.

During the past five years, subjects with similar red cell shape data but with greatly different symptoms have been observed. It is proposed that the local, regional, or systemic distribution of smaller-than-usual capillaries could explain why one individual becomes symptomatic and another individual does not become symptomatic. The same conditions could explain the variation in the range of intensity of symptoms perceived between individuals with similarly increased percentages of nondiscocytes in their peripheral blood.

Other observations support the proposal that increased percentages of crenated cells and echinocytes in the peripheral blood are both symptom provoking and fatigue provoking. Figure 2 shows two micrographs of the peripheral blood cells of a 38-year-old woman with a history of episodes of chronic tiredness and a moderate increase in the percentage of crenated cells. On a low dose of an antidepressant, she kept reasonably well except for occasional bouts of lethargy accompanied by severe headaches. She was asked to provide two blinded blood samples, one taken when she was unwell, the other taken when she was in good health. When she was well, crenated cells were not common (Figure 2A) but a severe, early morning headache was associated with a marked increase in such cells (Figure 2B). On being questioned about her activities on the day before her headache, she reported no unusual physical activity. When asked if there had been any stressful or emotional events, she told of a heated and emotional argument with a teenage daughter in the late evening. It is assumed that the changes in red cell shape were linked to the emotional upset and it is possible that they were catecholamine mediated. Red cell crenation occurred in the peripheral blood of a fit and healthy 31-year-old man after he had induced exhaustion in his right index finger by repeatedly pulling the trigger of a model pistol. In the pre-exercise sample (Figure 3A), 19.8 percent crenated cells had increased to 30 percent after fatigue of the index finger. These observations show that both emotional and exercise-related factors can worsen the red cell shape analysis results. This could be the mechanism why subjects suffering from chronic fatigue may suffer relapses after unusual levels of physical activity, emotional upsets, or stressful events.

Chronic tiredness also occurs in subjects whose blood contains increased percentages of cup forms (stomatocytes) in their peripheral blood, as in ME.[19] As previously reported,[26] a chance observation led to the finding that 50 percent of subjects with the symptoms of ME and increased percentages of cup forms benefitted from injections of vitamin B_{12}. Loss of symptoms with improved well-being within 24 hours was associated with a reduction in the percentage of cup forms and some subjects maintain reasonably good health with regular B_{12} injections. Those who felt no better after the vitamin injection showed no change in red cell shape. Such observations that show a relationship between symptoms and the percentage of nondiscocytes are consistent with the expected effects of poorly de-

formable cup forms and capillary blood flow. At the present time, this is the best direct evidence that links red cell shape changes to the symptoms of ME.

Current investigations have shown that different viruses have different effects on red cell shape. While some viruses appear to have no effects, others cause erythrocyte transformation to cup forms (stomatocytes) or to cells with altered margins (echinocytes). Although the effects of viruses on red cell shape have not been studied systematically, it seems possible that at least some part of the pathology associated with viral infections is due to the adverse effects on capillary blood flow and blood rheology, of virally transformed red cells. This view is supported by the results of a study of the effects of omega-3 and omega-6 fatty acids given as dietary supplements to subjects with PVFS.[27] While the authors concluded that the fatty acid supplements provided ". . . a rational, safe, and effective treatment," there was no mention of the literature that records the hemorheological effects of both series of fatty acids. For example, increased intake of gammalinolenic acid results in enhanced PGE_1 formation. PGE_1 has been shown by spin-labelling to improve erythrocyte membrane fluidity[28] and improves filtrability.[29] Cigarette smokers with poor blood filtrability showed improved filtrability after taking Efamol®, which is rich in gammalinolenic acid.[30] Kamada showed that omega-3-rich sardine oil improved membrane fluidity of diabetic red cells.[31] Thus, there is much published information that implies the beneficial effects of essential fatty acids in subjects with PVFS were a consequence of these effects on blood rheology.

These observations show that the symptoms of chronic tiredness/idiopathic chronic fatigue may occur when there are increased percentages of either cup forms (stomatocytes) or cells with altered margins (echinocytes), so that it is not red cell shape per se that is responsible for the symptoms but rather the effect of shape-transformed red cells on capillary blood flow and blood rheology. At the present time, lit-

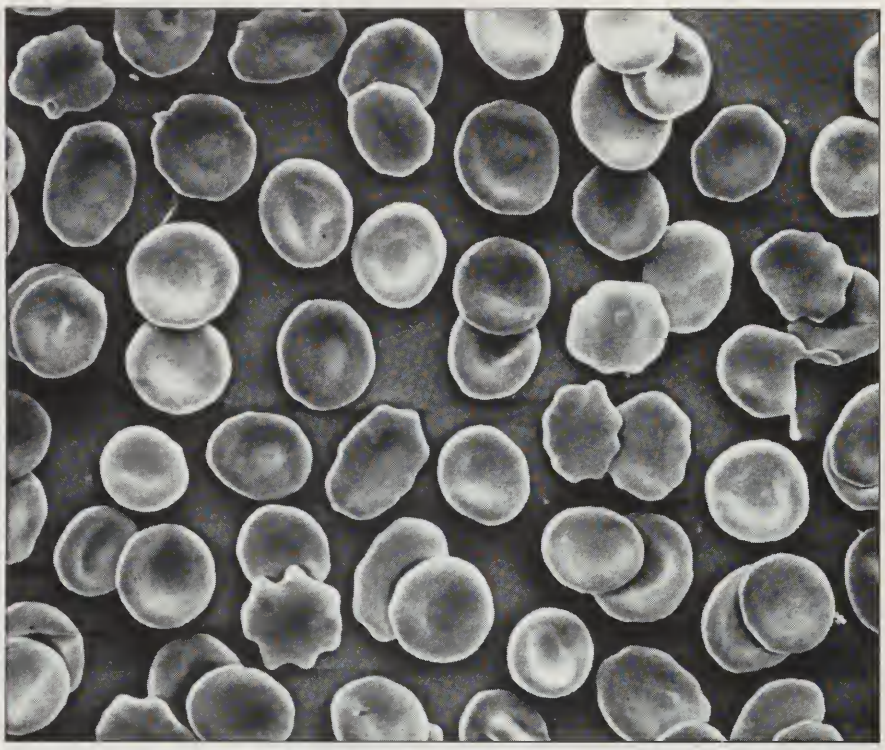


Figure 3A. Pre-exercise sample of a 31-year-old man. Red cell shape analysis results are: discoid cells, 71.9 percent; cells with surface changes, 7.5 percent; cup forms, 0.9 percent; and cells with altered margins, 19.8 percent.

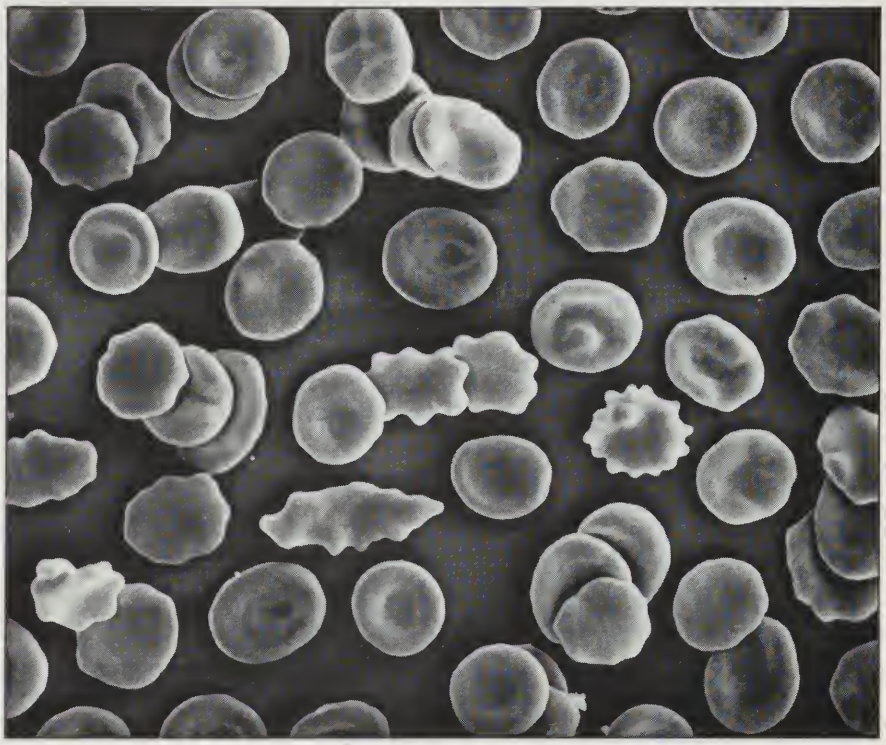


Figure 3B. A sample from a 31-year-old male after the induction of fatigue in the right trigger finger by repeated pulling of the trigger of a model pistol. Note that echinocytic cells are more mature and more frequent. Red cell shape analysis results are: discoid cells, 57.8 percent; cells with surface changes, 8.1 percent; cup forms, 4.1 percent; and cells with altered margins, 30.0 percent. Original magnification was 2000 x.

tle is known about the mechanisms of in vivo erythrocyte shape transformation.

Van Amberg wrote, "If we could agree on the presence of a chronic fatigue state, it also would be a boon to an apprehensive patient."[1] Patients who have the results of red cell shape analysis and a micrograph of their cells note improvement since learning that they had a recognizable abnormality. It seems likely that the emotional aspects of worrying over the unknown nature of their problem could worsen the degree of an existing red cell shape change. ■

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Dr. Simpson is affiliated with the Department of General Practice, University of Otago Medical School, New Zealand.

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Address reprint requests to Dr. Simpson, Department of General Practice, PO Box 913, Dunedin, New Zealand.

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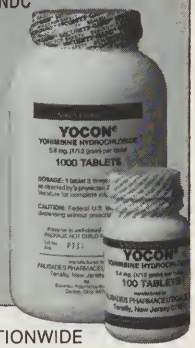
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Applying for and Renewing Institutional CME Accreditation Status

David E. Swee, MD
Bernardo Toro-Echague, MD
Palma E. Formica, MD

The MSNJ-Committee on Medical Education provides accreditation for most of the institutions in New Jersey that sponsor continuing medical education activities. The process of applying for accreditation is described, including the decision and appeal procedures.

Over the last 20 years, the quantity and quality of continuing medical education (CME) offerings to physicians in New Jersey have increased dramatically. What was once a smattering of programs now is a sophisticated series provided at local hospitals, medical schools, meetings, and conventions.[1-7]

Accreditation of hospitals and the institutions in New Jersey that sponsor CME is a responsibility of the Medical Society of New Jersey (MSNJ) through its Committee on Medical Education. The criteria and standards for accreditation (Essentials) have been established by the Accreditation Council for Continuing Medical Education (ACCME) and adopted by MSNJ (Table 1).

ACCME is a national organization with seven sponsors, including the American Medical Association, the Association of American Medical Colleges, and the American Hospital Association. Through its Committee for Review and Recognition (established in 1985), ACCME provides state medical associations with the authority to accredit intrastate organizations, institutions, or other entities.

ACCME also accredits organizations providing continuing medical education. These include medical schools, specialty societies, state medical societies, and other organizations with one quarter or more of their members from beyond the states bordering the organization's home base.[1] Similarly, any organization that advertises CME offerings beyond bordering states must be accredited by ACCME. Thus, the organizations accredited by MSNJ are providing local CME, primarily for physicians in New Jersey.

Since the majority of the medical staffs of New Jersey hospitals have bylaws that require 150 hours of CME credit within a three-year period to maintain staff privileges, the quality and quantity of such programs are important. In response to site visits and critiques from ACCME, the MSNJ Committee on Medical Education (MSNJ-CME) has upgraded its procedures for applying for such accreditation as well as for overseeing the ongoing programs that are provided.

Table 2 lists all organizations currently accredited by MSNJ for providing CME for New Jersey physicians. Among these, 57 organizations are fully accredited, 5 organizations are provisionally accredited, and 2 organizations are on probation. Within the last two years, 30 organizations were reaccredited, 5 organizations received new accreditation, 2 organizations applied but were not accredited, and 4 organizations withdrew their accreditation. The following discussion provides an overview of the procedures involved in applying for accreditation, from the initial site visit and the renewal site visit to the appeals process for any adverse decision.

ACCREDITATION PROCESS

The accreditation process involves a formal request for accreditation; submission of supporting application, appropriate documentation, site survey, and site survey report; and decision by MSNJ-CME regarding accreditation. There is a formal appeal process for any adverse accreditation decision. Programs that receive accreditation must submit a yearly CME Report Form. The Figure outlines the accreditation process.

APPLICATION PROCESS

A request for review of a CME program is initiated with a formal letter from the interested organization. An application form, a copy of the Essentials, and informational materials are mailed to the applicant. The survey application is completed and returned to MSNJ-CME along with

Table 1. *Essentials for continuing medical education.*

- **Mission Statement**
  - Goals of overall CME
  - Scope of CME
  - Characteristics of participants
  - General types of activities
- **Needs Assessment**
  - Documented process
  - Multiple data sources
  - Overall needs
  - Use in planning
- **Objectives**
  - Educational needs
  - Attending physicians
  - Requirements of participants
  - Instructional content
  - Objectives publicized
- **Program Design**
  - Responsive to prospective participants
  - Documented planning procedures
  - Publicized content and methods
- **Evaluation**
  - Periodically reviewed CME mission
  - Documented evaluation of objectives, instructional process, and participants' perception
  - Methods appropriate and consistent
  - Demonstrated use
- **Management Procedures**
  - Organizational structure
  - Responsible individuals
  - Internal review and control
  - Budget
  - Faculty
  - Facilities
  - Mechanisms to verify participation
- **Joint Sponsorship**
  - Evidence of integral participation
  - Evaluation

the application fee to cover the cost of the survey.

The survey application and supporting data are reviewed by MSNJ-CME staff for completion and conformity to the Essentials. Any deficiencies in the application are noted by the staff and the applicant is contacted for supplemental materials and/or revisions needed to properly complete the application.

If MSNJ-CME staff is not satisfied with the response of the organization, and the application remains deficient, the application with the staff summary is presented to MSNJ-CME. If the Committee concurs with the staff, the chairman addresses a letter to the responsible person at the applicant organization, with a list of deficiencies, an offer of consultative assistance prior to a reapplication, and a return of the application fee. A grace period of 30 to 90 days is permitted to make the necessary changes and reapplication for a survey.

Once the completed and properly executed application has been received, a site review is scheduled as expeditiously as possible and the applicant is notified of the survey date within 30 days.

CME SURVEY PROCEDURES

The application is reviewed prior to the survey. Surveyors may call MSNJ for clarification of any items or additional information. The MSNJ staff also communicates with the institution regarding the specific agenda and schedule of the survey visit.

During the survey, interviews are conducted with the overall program director, the chief administrative officer, and perhaps a trustee to assess attitude, support, and commitment to the program. Interviews also are conducted with members of the institution's medical education committee, and selected members of the institution's medical staff to assess involvement and perceptions of the program.

Documents are reviewed for insight into the planning and performance of the CME programs. Such reviews include inspection of attendance records, institutional bylaws (for the mission statement and CME requirements), committee minutes to assess planning, and quality assurance data. In addition, the team makes a tour of relevant facilities, e.g. conference space and medical library.

At the end of the survey, there is a brief discussion of any apparent weaknesses in the program and the applicant institution is given an opporunity to respond and to provide supporting documentation. After the site survey, the team prepares a structured report and the institution completes a review of the survey, both of which are submitted within 15 days after the survey.

DECISION AND APPEAL

Decision. MSNJ-CME discusses each site visit report. After a presentation by the survey team, MSNJ-CME makes a determination regarding accreditation of the applicant institution's CME program. Each institution that has been surveyed is notified by MSNJ-CME of its accreditation status within 30 days after the next regularly scheduled meeting of the Committee on Medical Education.

An accredited institution must announce its status on any publications regarding CME activities it provides using the following format: "The *(name of organization)* is accredited by MSNJ to sponsor continuing medical education for physicians."

An additional separate statement may be made regarding the number of credit hours provided for the particular activity in question, for example: "The *(name of organization)* designates attendance at this program as providing ____ hours of category ____ *(I or II)* credit toward the AMA Physician's Recognition Award."

Of note, while physicians may self-declare category II credits, an institution may only designate programs for category II credit if it already is accredited to provide CME activities for category I credits. Being accredited to provide CME activities for category I credits necessitates fulfilling all of the Essentials, as outlined in Table 1, and going through the survey process as described.

Accreditation types.

1. **Accreditation** is awarded to

institutions demonstrating the ability and resources to plan and to implement CME activities in accordance with the Essentials and Guidelines of MSNJ. Accreditation usually is granted for a period of four years and is contingent on providing a satisfactory annual CME Accreditation Report of the CME Program. At the Committee's discretion, some programs may receive accreditation for less than four years, in which case the institution will be supplied with the specific reasons for the Committee's decision.

2. **Provisional accreditation** is reserved for new applicants that satisfy accreditation standards and are approved by MSNJ-CME. This is a two-year accreditation requiring resurvey before termination of the two-year period. This accreditation also is contingent on providing a satisfactory annual CME Accreditation Report of the CME Program. Provisional accreditation is not renewable after the initial term.

3. **Probationary accreditation** is granted when an accredited institution has developed correctable deficiencies but is not in substantial compliance with the Essentials. The institution is given a period of 90 days to submit a corrective plan of action. Failure to do so results in loss of accreditation. If the corrective plan of action is approved, the probationary period is continued for one year at which time a resurvey is required. Probationary accreditation is not renewable.

4. **Nonaccreditation** is the status given to new applicant institutions failing to meet accreditation criteria, or for accredited institutions that no longer meet the criteria after a probationary period.

Figure. *Accreditation process.*

Application Process

- Interested organization submits formal letter to MSNJ.
- Application and Essentials mailed to applicant.
- Application completed and returned to MSNJ with fee.
- Staff review; if needed, additional materials submitted.
- MSNJ-CME reviews remaining deficiencies and writes applicant concerning deficiencies and necessary corrective actions (30 to 90 days).
- When application is completed, site survey is scheduled, within 30 days.

Survey Process

- Presurvey review of application. Surveyors meet to identify issues of concern.
- Communication between the institution and the survey team establishes specific agenda and schedule.
- Survey involves interviews, document review, tour of relevant facilities, and final discussion.
- Postsurvey, the team completes and submits the Survey Team Report Form within 15 days of site visit.
- Organization submits Survey Review Form within 15 days of site visit.

Accreditation Decision and Appeal

- MSNJ-CME considers each site visit report and decides on accreditation.
- Within 30 days, the organization is notified of MSNJ-CME's decision.
- Full accreditation: Requires submission of annual CME report.
- Provisional accreditation: For new applicants; must submit annual CME report; not renewable.
- Probationary accreditation: Correctable deficiencies; must submit plan for correction within 90 days (or else accreditation is lost); when plan submitted, probation is for one year; not renewable.
- Nonaccreditation: New programs or programs on probation that fail to meet criteria.
- Upon notification of denial of accreditation, applicant may submit written request for reconsideration to MSNJ-CME within 30 days.
- If MSNJ-CME sustains decision, applicant has 30 days to submit formal appeal.
- Upon receipt of formal appeal, MSNJ has 30 days to notify applicant of hearing date with Accreditation Review Team.
- A final appeal of a negative decision from the Accreditation Review Team may be made to the MSNJ Board of Trustees. The Board will appoint a special review committee; decision within 90 days.

Appeal. When accreditation is denied, MSNJ-CME notifies the institution, listing reasons for nonaccreditation. The institution may submit a request for reconsideration in writing to MSNJ-CME within 30 days. MSNJ-CME then considers this request at its next regularly scheduled meeting. If the adverse decision is sustained, the applicant institution is notified and has 30 days to submit a written request for a formal appeal.

A formal appeal can be submitted, with supporting information and data. MSNJ-CME will notify the institution within 30 days of a hearing date with the Accreditation Review Team. The Accreditation Review Team consists of at least two members from MSNJ and two consultants (none of whom participated in the original site survey). If the decision remains unfavorable, a final appeal may be made to the Board of Trustees within 30 days. In this way, the Board of Trustees functions as the final authority to hear and decide on the appeal.

If an appeal is made to the Board of Trustees, the Board appoints a special committee to review the appeal and the previous report of the Accreditation Review Team of MSNJ-CME within

Table 2. *Accredited institutions in New Jersey.**

- Atlantic City Medical Center
- Barnert Memorial Hospital Center
- Bayonne Hospital
- Bridgeton Hospital
- Carrier Foundation
- Centrastate Medical Center
- Children's Specialized Hospital
- Chilton Memorial Hospital
- Christ Hospital
- Clara Maass Medical Center
- Columbus Hospital
- Community Medical Center
- Cooper Hospital/University Medical Center
- Deborah Heart and Lung Center
- Dover General Hospital and Medical Center
- East Orange General Hospital
- Elizabeth General Medical Center
- Elmer Community Hospital
- Englewood Hospital
- Fair Oaks Hospital
- Hackensack Medical Center
- Helene Fuld Medical Center
- Holy Name Hospital
- Hospital Center at Orange
- Hunterdon Medical Center
- Jersey City Medical Center
- Jersey Shore Medical Center
- John F. Kennedy Medical Center
- Kimball Medical Center
- Meadowlands Hospital Medical Center
- Memorial Hospital of Burlington County
- Monmouth Medical Center
- Montclair Community Hospital
- Morristown Memorial Hospital
- The Mountainside Hospital
- Muhlenberg Regional Medical Center
- Newark Beth Israel Medical Center
- Newton Memorial Hospital
- Overlook Hospital
- Pascack Valley Hospital
- Point Pleasant Hospital
- Rahway Hospital
- Raritan Bay Medical Center/Perth Amboy General Hospital
- Riverview Medical Center
- Seton Hall University School of Graduate Medical Education
- Somerset Medical Center
- Saint Barnabas Medical Center
- Saint Michael's Medical Center
- Saint Peter's Medical Center
- St. Clare's Riverside Medical Center
- St. Elizabeth Hospital
- St. Francis Hospital
- St. Francis Medical Center
- St. James Hospital
- St. Joseph's Hospital and Medical Center
- St. Mary Hospital
- Underwood Memorial Hospital
- United Hospitals Medical Center
- Veterans Administration Hospital
- Veterans Administration Medical Center
- The Valley Hospital
- Warren Hospital
- Wayne General Hospital
- West Jersey Health Systems

*Accredited by MSNJ; University of Medicine and Dentistry of New Jersey (UMDNJ) and the Academy of Medicare of New Jersey (AMNJ) are accredited by ACCME.

90 days. The Board of Trustees makes the final decision based on both reviews. Institutions that have lost accreditation may reapply as new applicants after a six-month period.

Both the reconsideration and appeal are based on the status of the program at the time of the site survey and not on changes or corrective actions taken since the survey. If the institution wants its changes or corrective actions taken since the survey to be considered, it must submit a new application. Any action based on the reconsideration or the appeal are retroactive to the date of the survey. ■

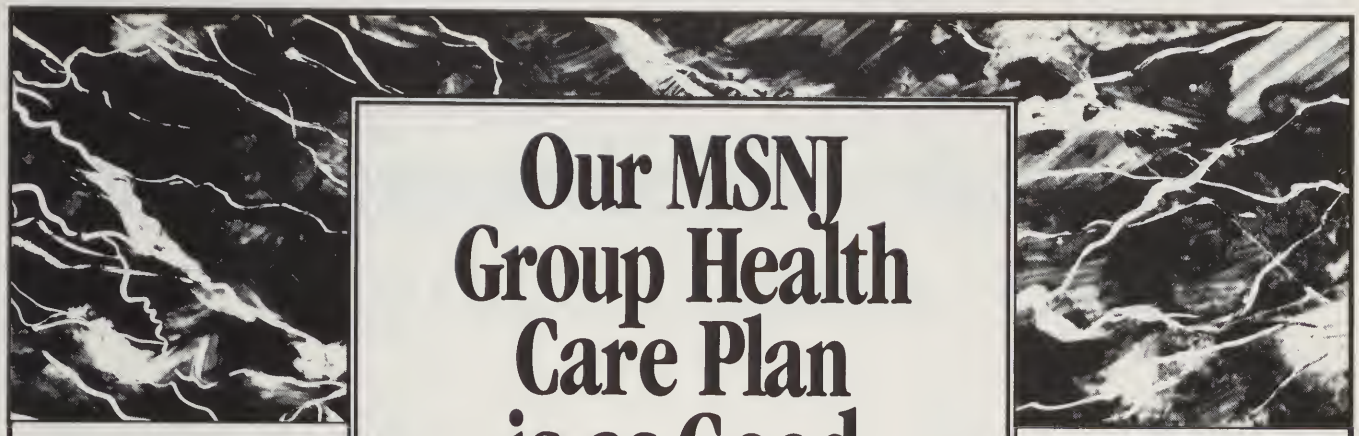
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Dr. Swee is vice-chairman, Dr. Toro-Echague is past chairman, and Dr. Formica is chairman, of the Committee on Medical Education of the Medical Society of New Jersey.

The paper was submitted in July 1991, and accepted in September 1991.

Requests for reprints may be addressed to Dr. Swee, UMDNJ-Robert Wood Johnson Medical School, CN 19, New Brunswick, NJ 08903-0019.



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OFFICIALLY ENDORSED BY MSNJ

History of Medicine: Hippocrates' Pseudoepigraphic Writings

Morris H. Saffron, MD

Although Hippocrates of Cos (460-379 B.C.) is mentioned with respect by such contemporaries as Plato, Aristotle, and Demosthenes, there is relatively little known about the actual career of the great physician.

Even during his lifetime, anecdotes relating to Hippocrates began to circulate; these were handed down from father to son until they eventually were included in the *Corpus Hippocraticum* and deposited in the library at Alexandria. Therefore, the letters I am reviewing should not be regarded as authentic and reliable documents but rather as legendary narratives about the man offering insight into his thoughts and personality. The 27 entries in the collection, admirably translated into English by a classical scholar and historian of medicine, fall into three sections: the first relates to Artaxerxes, Persian king of kings, who sends Hippocrates an invitation to become his medical consultant in combating the plague devastating his country. Despite the offer of abundant largesse, Hippocrates scornfully rejects the idea of coming to the assistance of an avowed enemy of the Greeks.

The second sequence of letters is by far the most extensive and illuminating. They concern the encounter between Hippocrates and the "Laughing Philosopher" Democritus, founder of the atomic theory of matter and the chief luminary of the city of Abdera. Members of the town council plead with Hippocrates to come and examine Democritus whom they believe is slowly going mad. Hippocrates agrees to accept the invitation and makes the necessary preparations for the visit. First, he invites Dionysius, a trusted friend to cover for him and to look after his affairs but also to keep an eye on his 'dear little wife' who might cast eyes on other men. He writes to another friend, Philopoimen, narrating a dream from which he deduces that Democritus is not mad at all, but is suffering from the effects of excessive study. From a third friend, the botanist, Crateuas, he requests a goodly supply of herbs, especially hellebore, a violent purgative, which he hopes he will not need to use. He finally sails on a ship supplied by still another friend and arrives at Abdera where he is greeted enthusiastically. On his meeting with the philosopher, he is greatly relieved to find that Democritus, as he already had surmised, is not at all insane but is suffering from too much study. As a matter of fact, Hippocrates finds him hard at work on a treatise on dementia, which condition Democritus attributes to a plethora of bile in the system. As for his constant and excessive laughter he explains this as a mocking of human society with all its frailties, transgressions, and wickedness. The two quickly become fast friends: Hippocrates calls Democritus the best and wisest of men while Democritus asks Hippocrates to teach him the art of medicine, although Hippocrates discourages him, pointing out that "medical men are allotted more reproach than honor" and points out that though now old, he has not reached the goal of medicine. The series of letters end with Hippocrates sending Democritus his treatise on hellebore, the drug he did not have to use.

The third section contains a letter from Hippocrates to his son, Thessalos, encouraging him to study mathematics as a science beneficial to the surgeon in estimating procedures on the bones and joints while, for the physician, mathematics is useful in predicting cycles and critical days of diseases. Also included in this section is a decree of the Athenian Council praising Hippocrates for controlling the plague in Athens and for refusing to aid the barbarians. He is to be initiated into the secrets of the great mysteries, and to be crowned with a golden crown.

As the reader may have surmised, this reviewer found these letters fascinating; the text is edited by Wesley D. Smith and E.J. Brill. We owe a debt of gratitude to Professor Brown for making this material readily available. Even though the content is medically unimportant and the portrait of Hippocrates is a pastiche, these letters bring us as close as we can ever hope to get to the mind and humanity of the revered Father of Medicine. ■

Case Report: Acute Appendicitis in an Inguinal Hernia

John M. Pellegrino, MD
Stephen D. Feldman, MD

Primary appendicitis presenting in a hernia sac is uncommon. Diagnosis depends on a high index of suspicion. The authors present a case report of a 65-year-old male with a two-day history of a painful irreducible right inguinal mass; he denied abdominal pain, nausea, vomiting, fever, or chills.

The presence of the appendix in an external hernia sac is not an unusual occurrence. It is estimated to occur in approximately 1 percent of cases.[1] Primary appendicitis presenting in a hernia sac, however, is a rare occurrence, estimated to occur in only 0.1 percent of all cases of appendicitis. Accurate preoperative diagnosis of this condition also is uncommon.

CASE REPORT

Our patient was a 65-year-old male with a two-day history of a painful irreducible right inguinal mass. He denied abdominal pain, nausea, vomiting, fever, or chills. Bowel movements were normal. His past history was significant for bilateral herniorrhaphies. The patient had been on oral antibiotics for paronychia.

His temperature was normal. Physical examination revealed a soft, nontender abdomen with bowel sounds present and a 3 x 3 cm firm irreducible mass in the right inguinal region.

Laboratory investigation revealed a white blood count of 17,800 k/cmm.

A diagnosis of incarcerated right inguinal hernia was made and the patient was taken to the operating room. An indirect hernia was found, its sac containing the inflamed appendix, which did not appear to have perforated. The appendix was removed, the hernia sac was resected, and the internal ring and abdominal wall were closed. The postoperative course was uneventful and the patient was discharged on postoperative day 7.

DISCUSSION

The appendix can present in either a simple or incarcerated hernia.[2] Acute appendicitis in an inguinal hernia is a rare occurrence. When it does occur, the majority of cases are reported in a right inguinal or femoral hernia.[3] In fact, the most common presentation of hernial appendicitis is in a femoral hernia sac in postmenopausal women.[4] The most frequent site in males is the right inguinal hernia sac[3] although several other sites including a left inguinal hernia,[5] umbilical hernia,[6] obturator hernia,[7] and incisional hernia[5] have been identified. There also have been several cases occurring in children.[8]

Accurate diagnosis of this condition depends on high clinical suspicion. The associated pain tends to be colicky in nature. Bachy and Rabourdin reported localized tenderness over the hernia to be a critical diagnostic finding.[5,9] Fever and leukocytosis are not always present.[1] Peritonitis is the most serious complication of this condition.[3]

Appendectomy through a herniotomy with primary hernia repair is the treatment of choice. In his series, Carey reported a mortality rate of 30 percent with appendiceal perforation.[5] Other studies have reported a 50 percent wound infection rate.[1]

CONCLUSION

Acute appendicitis presenting in an inguinal hernia is a rare condition. The diagnosis usually is made postoperatively. A high index of suspicion must be maintained in order to avoid the more serious consequences of appendiceal rupture. ■

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Drs. Pellegrino and Feldman are affiliated with the Department of Surgery, Saint Barnabas Medical Center, Livingston. The paper was submitted in July 1991 and accepted in October 1991. Address reprint requests to Dr. Pellegrino, Saint Barnabas Medical Center, Livingston, NJ 07039.

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MAY 3-6, 1992

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DOCTORS' NOTEBOOK

TRUSTEES' MINUTES

A regular meeting of the Board of Trustees was held on January 19, 1992, at the executive offices in Lawrenceville. Detailed minutes are on file with the secretary of your county society. A summary of significant actions follows:

President's Report. Noted the following items: appointment of a physician to serve as MSNJ's representative to the New Jersey State Department of Health (NJDOH) to help formulate a State Health Plan; appreciation from Dr. Dunston for MSNJ's support and input into various efforts of NJDOH, particularly in the development of the AIDS testing policy; personal letter to all New Jersey obstetricians/gynecologists will be sent from Dr. Riggs and Dr. Dunston recommending HIV testing be included as part of the routine tests performed on pregnant women; and the importance of meeting legislators—especially newly elected legislators—to bring them up to date on current issues.

Specialty Reports. Received reports from Stanley S. Bergen, Jr, MD, president of the University of Medicine and Dentistry; Louis Scibetta, president and chief executive officer of the New Jersey Hospital Association; Drs. Louis L. Keeler and Ian D. Samson from their meeting with Pennsylvania Blue Shield; and MSNJ Auxiliary.

Report of Executive Director.

1. MSNJ Membership. Received a membership report.

2. MSNJ Financial Statements. Reviewed and approved MSNJ's financial statements, noting that there is increased activity in the fields of public relations and litigation.

3. Litigation. Noted that the case of MSNJ versus the State Board of Medical Examiners (SBME) regarding physician assistants will remain open until arguments are heard, although Judge Stern may make a motion to have the state retract its regulation, which would allow dismissal of the suit.

4. Legislation. Noted the following: Mandatory Assignment—a major victory for MSNJ; Nurse Practitioners—will pursue an amendment in the upcoming legislative session; Physician Assistants—passed in the Legislature; Optometric Bill—passed by one vote in the Assembly and one vote in the Senate and the governor signed it into law; and Medical Licensing—MSNJ's bill providing for "clear and convincing evidence" was passed in the Assembly and Senate and is on the governor's desk.

5. Patient Records. Reviewed a proposed regulation by SBME to modify the existing regulation on the preparation of patient records.

6. Mail Ballot by House of Delegates. Referred the issue of mail balloting to the Committee on Revision of Constitution and Bylaws; if the Committee feels MSNJ can conduct a ballot of the House via mail when a single issue arises, an amendment will be prepared and submitted to the Board for approval.

7. RBRVS: An Update. Noted that Mr. Maressa urged all physicians to read the RBRVS report from Kirk B. Johnson, JD, general counsel and senior vice-president of the AMA; the report lists reasons why the AMA will not initiate legal action against the Health Care Financing Administration (HCFA) at this time.

8. Third-Party Payments. Discussed problems associated with the new codes.

Council on Medical Services. The following recommendations were approved:

That the Board of Trustees write to Raymond C. Allen, Jr, The Prudential Insurance Company of America,

MEETINGS OF THE BOARD OF TRUSTEES of the Medical Society of New Jersey

March 15, 1992
April 15, 1992

Meetings of the Board of Trustees are open to all physicians. The meeting on March 15, 1992, is an OPEN FORUM, to allow physicians the opportunity to stand up and be heard. If you would like to attend the OPEN FORUM, please contact Diana Gore, MSNJ headquarters, 609/896-1766.

requesting certification and appropriate documentation that the review of (Dr. Schwartz's) cases was conducted by an orthopaedist.

That a letter be written to the Department of Insurance and the State Board of Medical Examiners, requesting their standards of professional review regarding fee review by a physician of the same specialty.

Council on Mental Health. Referred the recommendation back to the Council for clarification of its language and intent:

That the Board of Trustees urge the AMA to include in the Health Access America Plan the following psychiatric benefits: schizophrenia, schizoaffective disorder, bipolar disorder, delusional depression and pervasive developmental disorder, as well as other life threatening or gravely disabling mental disorders where there is a threat to the life of the patient or others, e.g. suicidal patients, severe anorexia.

Awards Committee. Approved the following recommendation:

That the Board of Trustees establish an Awards Committee to make recommendations to the AMA and New Jersey-based associations regarding Society-endorsed nominees for medical, scientific, and citizen awards.

Committee on Cancer Control. Adopted the following resolution:

Resolved, that the Medical Society of New Jersey encourage the use of all appropriate measures by its members to eliminate the sale of tobacco products in New Jersey retail pharmacies.

Committee on Environmental Health. Approved the following recommendations:

That the State Department of Environmental Protection and Energy establish emission standards for heavy metal air pollutants based upon their impact on health.

That the State Department of Environmental Protection and Energy establish standards for mercury, based upon its impact on health.

Unfinished Business. Authorized the following physicians to attend the AMA Leadership Conference: Drs. Karl Franzoni, Joseph Riggs, Harry Carnes, Joseph Micale, William Ryan, G. Gerson Grodberg, A. Ralph Kristeller, Mark Olesnicky, Leticia DeCastro, and R. Gregory Sachs.

New Business.

1. AMA Delegate Allocation for 1992. Was advised that due to a drop in AMA membership, New Jersey's delegate count dropped to nine delegates.

2. Blue Cross/Blue Shield Insurance Coverage. Noted that Blue Cross/Blue Shield is receptive to working out a solution and MSNJ is hopeful that in the future the plan filed with the State Insurance Department will indicate that physicians may be insured on a community rated basis if they are eligible for membership in the Society and have not availed themselves of membership.

3. Schedule II Prescriptions in Long-Term Care Facilities. Agreed to instruct the AMA Delegation to prepare a resolution for submission to the AMA House of Delegates regarding a

1992 MSNJ Annual Meeting Proposed Daily Schedule

Saturday, May 2, 1992

3:30 p.m. Board of Trustees' Meeting

Sunday, May 3, 1992

8:00 a.m. Registration Opens
9:30 a.m. Message Center Opens
10:00 a.m. Educational Program
11:30 a.m. Exhibits Open
2:00 p.m. House of Delegates
3:30 p.m. Reference Committee Meetings

Monday, May 4, 1992

8:00 a.m. Registration Opens
8:00 a.m. Message Center Opens
8:30 a.m. Exhibits Open
9:00 a.m. House of Delegates (Election)
12:00 noon Golden Merit Award Ceremony and Reception
2:30 p.m. Reference Committee Meetings
5:00 p.m. JEMPAC Political Forum
5:45 p.m. JEMPAC Wine and Cheese Reception
6:30 p.m. Camden County Medical Society Reception

Tuesday, May 5, 1992

8:00 a.m. Registration Opens
8:00 a.m. Message Center Opens
8:30 a.m. Exhibits Open
9:00 a.m. House of Delegates
1:30 p.m. House of Delegates
2:00 p.m. Exhibits Close
7:00 p.m. Inaugural Reception and Dinner

Wednesday, May 6, 1992

8:00 a.m. Registration Opens
8:00 a.m. Message Center Opens
8:30 a.m. General Session (Educational Program)
1:00 p.m. Board of Trustees' Meeting

proposal by NJDOH that would amend certain sections of the Controlled Dangerous Substances regulations to change the procedure on issuance of a prescription and the method of allowing for partial filling of a schedule II substance in a long-term care facility or for a person with a medical diagnosis documenting a terminal illness; the regulations bring the state statute into conformity with federal law.

4. Medicare Program: Standard Claim Forms for Part B. Noted that MSNJ will forward comments to HCFA in opposition to the proposal that effective April 1, 1992, Medicare carriers no longer will accept nonstandard claim forms (superbills are included in the proposal). □

MSNJ AUXILIARY

The spirit of volunteerism continues to thrive in county auxiliaries.

Atlantic County Medical Society Auxiliary held a successful boutique and luncheon featuring a lecture on living wills. Proceeds were used for health career scholarships.

Burlington County Medical Society Auxiliary hosted an "All Chopin Piano Concert" and dinner party for 50 people. A total of $1,050 was raised for the American Medical Association-Education and Research Foundation (AMA-ERF).

Camden County Medical Society Auxiliary sponsored a cultural trip to Ellis Island and a fundraising theater trip to New York City. The highly successful events realized a profit of $3,100. The Auxiliary also held a luncheon meeting honoring 50-year members; nine women were recognized for their years of service.

Cape May County Medical Society Auxiliary is busy working on its "Safe Ride" program. Last month, the Cape May Kiwanis Club donated car seats to the Auxiliary to use at Burdette Tomlin Hospital. Cape May Auxiliary members also raised funds to provide five health career scholarships to county residents.

Essex County Medical Society Auxiliary cosponsored a political forum to give members the opportunity to meet the candidates running for the New Jersey Senate and Assembly. Also, Auxiliary members continue to distribute "safe toys" at Children's Hospital, Newark.

Gloucester County Medical Society Auxiliary, continuing its "Adopt-A-Nursing Home" program, presented the county's Shady Lane Nursing Home with two "gerry chairs." In addition, the Auxiliary and Underwood-Memorial Hospital cosponsored a community service seminar, "Living Wills, Advanced Directives, and Organ Donations."

Mercer County Medical Society Auxiliary, in keeping with the theme, "Person to Person—Sharing Our Resources," collected household goods, clothing, and other recyclable items for the needy. They are focusing on provisions for the growing elderly population. The Auxiliary also plans to purchase a copier for Katzenbach School for the Deaf.

Monmouth County Medical Society Auxiliary, reorganized last year, presented "A Special Touch," a combined luncheon-fashion show with a self-breast examination program that included certification; proceeds went to the Cancer Society and the Riverview Medical Center Hospital Hospice. Other fundraisers included a wine-and-cheese tasting party to benefit the Pediatric AIDS Foundation.

Morris County Medical Society Auxiliary joined its medical society members in a campaign against mandatory Medicare assignment. The Auxiliary also contacted the administrators of the

Women in Medicine

Monday, May 4, 1992
12:15 P.M.

Topaz Room—Section B
Trump Taj Mahal Casino/Resort
Atlantic City, New Jersey

Guest Speaker:

Christine Todd Whitman
"Women Physicians in Public Affairs"

Ms. Whitman attained national prominence in 1990 when she almost unseated Senator Bill Bradley. Now that Ms. Whitman is a proven vote-getter, she is widely considered the front-runner for the 1993 Republican nomination for governor of New Jersey.

Sponsored by MSNJ Committee on Women in Medicine
Luncheon charge: $30

Reservation Deadline: April 17, 1992

Send form and check made out to MSNJ
Attention: Marge Bolling
2 Princess Road, Lawrenceville, NJ 08648

"Women Physicians in Public Affairs"

Name: _____

Address: _____

Phone: _____ No. reservations_____

county's 13 nursing homes and offered them a $500 wish list. Presentations were made on Valentine's Day.

Passaic County Medical Society Auxiliary continued its tradition of making Sunday brunch for medical families. In addition to promoting unity and comraderie, the Sunday brunch raised $1,500 for charity.

Salem County Medical Society Auxiliary coordinated "Health Careers Day" at Salem Hospital. Five guidance directors and 24 students toured the hospital and discussed health careers with physicians, nurses, technicians, laboratory technicians, and x-ray personnel. The December "Mistletoe Ball" raised a record $7,000 for the Auxiliary's Jonas Nursing Scholarship. Auxiliary members also are involved in providing food and supplies to the Salem Crisis Center.

Union County Medical Society Auxiliary held a champagne brunch and raffle to benefit its medical-nursing scholarships and its "Safe-Ride" car seat program. Auxiliary members also collected food for the battered women's shelter. Members and physicians attended a Union County senior citizens' luncheon and participated in a question-and-answer session.

Warren County Medical Society Auxiliary provided three health screenings—cholesterol, eye, and oral cancer, and hosted "Art for Oncology Exhibition and Tea" at Warren Hospital. Two county artists donated 36 works of art for part of a permanent collection to adorn the walls of the oncology unit at Warren Hospital.

Congratulations to all the counties and the fine work their members are doing as volunteers for good health in their communities. ☐ Marion H. Geib

UMDNJ NOTES

UMDNJ honors Congressman Dwyer. Congressman Bernard J. Dwyer (D-6th District) was awarded the University Medal for Distinguished Leadership at UMDNJ's eighth annual University Day observance. The event included the president's traditional State-of-the-University address, which focused on UMDNJ's partnerships, and the presentation of annual University Excellence Awards to employees.

In its citation to Representative Dwyer, the Board of Trustees noted: "Congressman Bernard J. Dwyer has won respect and affection from his colleagues and our citizens by consistently being the champion of programs addressing the unique health care needs of children, senior citizens, minorities, and women."

In his address, the president noted that UMDNJ has continued to grow—despite state funding cutbacks—through increased revenues from grants and patient-care services and a dynamic network of partnerships with hospitals, educational institutions, and industry.

The following employees received Excellence Awards:

Biomedical research—Dr. John W. Prineas, professor of neurosciences, UMDNJ-New Jersey Medical School, Newark.

Education—Dr. Frances W. Quinless, associate professor and chair of nursing education and services, UMDNJ-School of Health Related Professions, Newark.

Patient care—Dr. Lawrence J. Ettinger, associate professor and section head of pediatrics, UMDNJ-Robert Wood Johnson Medical School, New Brunswick.

Service and outreach to the external community—Robin Eubanks, assistant professor of academic and student services, UMDNJ-School of Health Related Professions.

Service to the University—Barbara S. Irwin, librarian/archivist, George F. Smith Library of the Health Sciences, Newark.

Support for University quality of life—Charles D. McKinney, Jr, property control assistant, Department of Asset Management/Financial Affairs, Newark.

Doctors Office Center nears completion. Construction of a $55 million UMDNJ-New Jersey Medical School Doctors Office Center and parking garage on UMDNJ's Newark campus is almost complete. The facility will be open soon. The building and a connected, secure parking garage are located in Newark's University Heights section, at the Bergen Street-12th Avenue corner of the 46 acre UMDNJ campus. The eight-level, 154,000 square foot structure will ultimately be occupied by 400 academic physicians, who will provide a diverse array of vital health care services for northern New Jersey.

Culminating over a decade of planning, the facility will allow UMDNJ to significantly expand the medical services, research, and educational programs carried out by the faculty of UMDNJ-New Jersey Medical School.

Eric Mitchell joins UMDNJ Board of Trustees. Eric Mitchell of Newark is the newest member of the Board of Trustees of UMDNJ. He is the legislative aide to State Senator Ronald L. Rice (D-28th) and a financial and real estate consultant. His expertise will be a great asset to the Board.

Dean Lourenco named to Project 3000 by 2000 committee. Dr. Ruy V. Lourenco, dean of UMDNJ-New Jersey Medical School, has been named to a nationwide initiative to increase the number of minority students in American medical schools. He joins an implementation committee of Project 3000 by 2000, the campaign of the Association of American Medical Colleges (AAMC). The Association, representing 126 accredited U.S. medical schools, plans to increase the number of entering minority students to 3,000 by the year 2000. ☐ Stanley S. Bergen, Jr, MD

AMNJ REPORT

The Academy of Medicine of New Jersey (AMNJ) and the Medical Society of New Jersey are sponsoring three major symposia entitled, "The Expanding Clinical Spectrum of HIV Disease." The programs are funded through a grant from the New Jersey State Department of Health, Division of AIDS Prevention and Control. They will be held on May 6, 1992, Taj Mahal, Atlantic City; May 11, 1992, Radisson Hotel, Newark Airport; and May 12, 1992, Sheraton Poste Inn, Cherry Hill.

Dr. Richard E. Dixon of the Helene Fuld Medical Center and chairman of the series will discuss tuberculosis in the HIV era. Dr. John W. Sensakovic of Saint Michael's Medical Center will present a lecture, "Sexually Transmitted Diseases in the HIV Era." Dr. George McSherry of the Children's Hospital of New Jersey will discuss AIDS in children. Dr. Deborah Cotton of the Division of Infectious Diseases at Beth Israel Hospital, Boston, will be the keynote speaker at the May 11 and 12, 1992, events. She will address AIDS in women. For further information, call Margo Churchwell at AMNJ executive offices.

On March 21, 1992, AMNJ and the Radiological Society of New Jersey will sponsor a one-day seminar on clinical mammography at the Hyatt Regency, New Brunswick. Dr. Lester Kalisher of Saint Barnabas Medical Center is program chairman. The program is directed at radiologists, obstetricians/gynecologists, and primary care physicians. The program objectives are to increase the participants knowledge of effective problem solving methods in mammography, to improve understanding of equipment, technique, and medical legal implications, and to familiarize physicians with interventional techniques used in breast diagnosis.

The 1992 schedule for the New Jersey Physicians' Golf Association (NJPGA) will be mailed this month. NJPGA plans to hold six tournaments this year. Information on NJPGA membership is available by contacting Lisa Swartek at AMNJ executive offices.

Plans are moving forward for AMNJ's Annual Awards Dinner on May 27, 1992, at the Chanticler in Short Hills. The Awards Committee has sent solicitation letters to all Academy fellows and friends requesting support for the Sponsor's Book to commemorate the occasion and raise funds for AMNJ's Education Fund. For further information on the dinner and this fundraiser, call Linda Bartolo at AMNJ executive offices.

AMNJ continues to expand its specialty society management services. The following organizations have been added to our growing list: New Jersey Pediatric Society; New Jersey Association for Ambulatory Surgery Centers; and American College of Obstetrics and Gynecology (ACOG) District III. ☐ Gerald Shapiro, MD, President

PLACEMENT FILE

The following physicians have written to the executive offices of MSNJ seeking information on opportunities for practice in New Jersey. If you are interested in any further information, please contact the physician directly.

Cardiology

Alan E. Kravitz, MD, 26900 Cedar Rd., #304, Beachwood, OH 44122. Jefferson 1969. Also, internal medicine. Board certified. Also, board certified (IM). Group or partnership. Available.

Endocrinology

Muriel Levy-Kern, MD, 90 Fleet Pl., Mineola, NY 11501. Universite Pierre et Marie Curie Faculte De Medicine (Paris) 1985. Board eligible. Group practice. Available June 1992.

Internal Medicine

Thomas F. De Blasio, MD, 100 Franklin St., Apt. 8B8, Morristown, NJ 07960. St. George's 1985. Board eligible. Solo or partnership. Available July 1992.

Sheryl S. Hertel, MD, 6205 Brogan Pl., St. Louis, MO 63128. St. Louis 1986. Also, pediatrics. Board certified; board eligible (PED). Group. Available.

Alan E. Kravitz, MD, 26900 Cedar Rd., #304, Beachwood, OH 44122. Jefferson 1969. Also, cardiology. Board certified. Also, board certified (C). Group or partnership. Available.

Cynthia K. Menack, MD, 3132 Perry Ave., Apt. 2A, Bronx, NY 10467. Mount Sinai 1989. Board eligible. Group practice or medical clinics. Available July 1992.

John Musico, MD, 262 Pine Valley Rd., Dover, DE 19901. St. George 1988. Board eligible. July 1992.

Pathology

Sarita Khanijo, MD, 1710 NW Calkins, Roseburg, OR 97470. MGM Medical College (India) 1976. Board certified. Group or partnership. Available.

Pediatrics

Sheryl S. Hertel, MD, 6205 Brogan Pl., St. Louis, MO 63128. St. Louis 1986. Also, internal medicine. Board eligible. Board certified (IM). Group. Available.

Pulmonary Medicine

Vinod Khanijo, MD, 1710 NW Calkins, Roseburg, OR 97470. Delhi University (India) 1963. Board certified. Solo. Available July 1992.

Surgery

Victoria Lee, MD, 459 South St., #204, Fitchburg, MA 01420. Howard 1981. Board certified. Group, HMO, partnership. Available.

David M. Lemonick, MD, 957 North 6 St., New Hyde Park, NY 11040. NY Medical College 1981. Board certified. Also, board eligible (CARDIO-THOR). Private group. Available July 1992. ☐

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Wednesdays 8:30 a.m.-9:30 a.m.

March-May 1992

MARCH 1992

March 4, 1992
CLINICAL PATHOLOGICAL CONFERENCE: VIOLANCEOUS MACULAR RASH, HEPATOMEGALY, FEVER & NEUROLOGIC ABNORMALITIES
Edward Dimitry, M.D.
Chief Resident, Department of Medicine
Hahnemann University
Cathy Jensen, M.D.
Chief Resident, Department of Medicine
Hahnemann University
Richard Maniglia, M.D.
Chief Resident, Department of Medicine
Hahnemann University
Jay Patel, M.D.
Chief Resident, Department of Medicine
Hahnemann University

March 11, 1992
CARDIOLOGY—ISSUE AND ANSWERS FOR THE 90's
Sylvan L. Weinberg, M.D.
Clinical Professor of Medicine
Wright State University
Dayton, OH

March 18, 1992
OCULAR MANIFESTATIONS OF AUTOIMMUNE DISEASE
Stephen Sinclair, M.D.
Professor of Ophthalmology
Vice Chairman, Department of Ophthalmology
Hahnemann University

March 25, 1992
HYPERTENSIVE NEPHROSCLEROSIS: IS IT BENIGN?
Jerome Porush, M.D.
Professor of Medicine
SUNY Health Science Center
Chief, Nephrology and Hypertension
Brookdale Hospital and Medical Center
Brooklyn, NY

APRIL 1992

April 1, 1992
CURRENT CONTRACEPTIVE MANAGEMENT: BENEFITS AND RISKS
Richard A. Baker, M.D.
Professor and Vice Chairman
Department of Obstetrics and Gynecology
Hahnemann University

April 8, 1992
PRINCIPLES GOVERNING THE USE OF THROMBOLYTIC AGENTS
Burton E. Sobel, M.D.
Lewin Professor of Medicine
Director, Cardiovascular Division
Washington University School of Medicine
St. Louis, MO

April 15, 1992
INTRAVASCULAR CATHETER-RELATED INFECTIONS
Dennis G. Macki, M.D.
Professor of Medicine
Chief, Section of Infectious Diseases
University of Wisconsin Medical School
Madison, WI

April 22, 1992
NUTRITIONAL SUPPORT IN THE CRITICAL CARE UNIT
Rosemarie L. Fisher, M.D.
Associate Professor of Medicine
Division of Digestive Diseases
Department of Internal Medicine
Yale University School of Medicine
New Haven, CT

ENDOSCOPIC MANAGEMENT OF BILIARY TRACT DISORDERS
Jerome H. Siegel, M.D.
Associate Professor of Medicine
Mt. Sinai School of Medicine
Chief, Endoscopy Unit
Beth Israel Medical Center North
New York, NY

April 29, 1992
DEVELOPMENT OF SKIN SUBSTITUTES
Richard L. Spielvogel, M.D.
Professor of Medicine and Dermatology
Director, Division of Dermatology
Hahnemann University

MAY 1992

May 6, 1992
HYPERTENSION IN PREGNANCY
Robert W. Schrier, M.D.
Professor and Chairman
Department of Medicine
University of Colorado School of Medicine
Denver, CO

May 13, 1992
INVASIVE VERSUS NONINVASIVE ASSESSMENT OF VALVULAR HEART DISEASE
Richard Gorlin, M.D.
Professor and Chairman
Department of Medicine
Mt. Sinai School of Medicine
New York, NY

May 20, 1992
PARANEOPLASTIC ENDOCRINE SYNDROMES
Kenneth L. Becker, M.D., Ph.D.
Professor of Medicine and Physiology
Director, Division of Endocrinology
George Washington University Medical Center and VA Medical Center
Washington, DC

May 27, 1992
GUILLAIN-BARRÉ-STROLLE SYNDROME
Michael Sherman, M.D.
Assistant Professor of Medicine
Director, Pulmonary Function Laboratory
Division of Allergy, Critical Care & Pulmonary Medicine
Hahnemann University
Seth Tarras, M.D.
Assistant Professor of Neurology
Director, EMG Laboratory
Director, ALS Center
Department of Neurology
Hahnemann University
Scott Hessen, M.D.
Assistant Professor of Medicine
Clinical Electrophysiology Laboratory
Likoff Cardiovascular Institute
Hahnemann University

Hahnemann University Department of Medicine
Wednesday Medical Seminar Series
8:30 a.m.-3:30 p.m.

March 24-25, 1992
ADVANCES IN KIDNEY DISEASE

April 22, 1992
UPDATE IN GASTROENTEROLOGY, NUTRITION, AND ENDOSCOPY

May 5-6, 1992
HYPERTENSION AND KIDNEY DISEASE

Seminar Director:
Allan B. Schwartz, M.D.
Professor of Medicine
Director, Continuing Medical Education for the Department of Medicine

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CONTINUING EDUCATION

DERMATOLOGY

April

1 **Dermatology Grand Rounds**
8 6-9 P.M.—Rutgers Community
15 Health Plan, New Brunswick
22 *(UMDNJ)*
29

14 **Monthly Meeting**
7 P.M.—Schering Corporation, Kenilworth
(Dermatological Society of New Jersey and AMNJ)

May

6 **Dermatology Grand Rounds**
13 6-9 P.M.—Rutgers Community
20 Health Plan, New Brunswick
27 *(UMDNJ)*

INFECTIOUS DISEASE

April

3 **Inter-Jersey Infectious**
10 **Disease Rounds**
17 Hackensack Medical Center,
24 Newark Beth Israel Medical Center, St. Joseph's Hospital and Medical Center, Overlook Hospital, and University Hospital
(UMDNJ and AMNJ)

3 **Identification and Management of the HIV Indeterminant Infant**
12 Noon-1 P.M.—South Jersey Hospital System, Bridgeton
(AMNJ)

8 **Findings of the Perinatal AIDS Project**
12:15-1:30 P.M.—Health and Agriculture Building, Trenton
(AMNJ and NJDOH)

9 **Identification and Management of the HIV Indeterminant Infant**
9-10 A.M.—Saint Barnabas Medical Center, Livingston
(AMNJ)

14 **Diagnosis and Treatment of AIDS**
11 A.M.-12 Noon—West Jersey Health System, Voorhees
(AMNJ and NJDOH)

15 **Identification and Management of Asymptomatic HIV Infection**
12:30-1:30 P.M.—Central New Jersey Medical Group, Somerset
(AMNJ)

16 **Identification and Management of the HIV Indeterminant Infant**
12 Noon-1 P.M.—Hospital Center at Orange, Orange
(AMNJ)

17 **Identification and Management of the HIV Indeterminant Infant**
8-9 A.M.—Newcomb Medical Center, Vineland
(AMNJ)

17 **Identification and Management of Asymptomatic HIV Infection**
11 A.M.-12 Noon—Chilton Memorial Hospital, Pompton Plains
(AMNJ and NJDOH)

21 **Identification and Management of Asymptomatic HIV Infection**
11 A.M.-12 Noon—St. Mary's Hospital, Hoboken
(AMNJ)

23 **Identification and Management of Asymptomatic HIV Infection**
1-2 P.M.—Mt. Carmel Guild CMHC, Newark
(AMNJ)

23 **Identification and Management of the HIV Indeterminant Infant**
3-4 P.M.—DYFS Medical Unit, Lawrenceville
(AMNJ)

28 **Identification and Management of the HIV Indeterminant Infant**
8-9 A.M.—Memorial Hospital of Burlington County, Vineland
(AMNJ)

29 **Identification and Management of Asymptomatic HIV Infection**
11 A.M.-12 Noon—New Lisbon Developmental Center
(AMNJ)

29 **Identification and Management of Asymptomatic HIV Infection**
12 Noon-1 P.M.—South Jersey Hospital System, Bridgeton
(AMNJ and NJDOH)

May

1 **Inter-Jersey Infectious**
8 **Disease Rounds**
15 Hackensack Medical Center,
22 Newark Beth Israel Medical
29 Center, Saint Joseph's Hospital and Medical Center, Overlook Hospital, and University Hospital
(UMDNJ and AMNJ)

1 **Diagnosis and Treatment of AIDS**
12 Noon-1 P.M.—Southern Jersey Hospital System, Bridgeton
(AMNJ and NJDOH)

6 **AIDS Spring Conference**
8:30-11:30 A.M.—MSNJ Annual Meeting, Trump Taj Mahal Casino/Resort, Atlantic City
(AMNJ and MSNJ)

11 **AIDS Spring Conference**
8:30 A.M.-1:45 P.M.—Radisson Hotel, Newark Airport
(AMNJ and NJDOH)

11 **Identification and Management of Asymptomatic HIV Infection**
7-8 P.M.—Wallkill Valley Hospital, Sussex
(AMNJ and NJDOH)

12 **AIDS Spring Conference**
8:30 A.M.-1:45 P.M.—Sheraton Poste Inn, Cherry Hill
(AMNJ and NJDOH)

13 **Diagnosis and Treatment of AIDS**
3-4 P.M.—St. Joseph's Hospital and Medical Center, Clifton
(AMNJ)

15 **Identification and Management of the HIV Indeterminant Infant**
1-2 P.M.—Medical Center at Princeton, Princeton
(AMNJ)

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June 13, 1992
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These meetings are co-sponsored by the International College of Acupuncture & Electro-Therapeutics & its official journal, Acupuncture & Electro-Therapeutics Research, The International Journal (published by Pergamon Press & indexed in 15 major indexing periodicals, including Index Medicus), Heart Disease Research Foundation; NY Pain Center; Electrical Engineering Dept., Manhattan College; Nordic Medical Acupuncture Society (Scandinavia); Schmerz Therapeutische Kolloquium (West Germany); Japan Bi-Digital O-Ring Test Assn.; Accredited toward Acupuncture Certification to practice acupuncture. Eligible for AMA CME Cat. I credit (about 40 credit-hours for the Symposium).

For information on meetings or submission or presentations of papers, contact Symposium Chairman, Prof. Y. Omura, M.D., Sc.D., 800 Riverside Drive (8-I) New York, NY 10032 Tel: (212) 781-6262 (10 am to 10 pm 7 days a week) or (212) 928-0658, Co-chairman, Prof. A.W. Cook, MD (516) 877-1821, or Bro. Michael Losco (212) 920-0162.

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15 **Identification and Management of Asymptomatic HIV Infection**
9-10 A.M.—St. Francis Medical Center, Trenton
(AMNJ and NJDOH)

19 **Diagnosis and Treatment of AIDS**
11:30 A.M.-12 Noon—Rahway Hospital, Rahway
(AMNJ and NJDOH)

20 **Hepatitis**
2:30-3:30 P.M.—Ancora Psychiatric Hospital, Hammonton
(AMNJ and NJDOH)

20 **Identification and Management of the HIV Indeterminant Infant**
8-9 A.M.—Warren Hospital, Phillipsburg
(AMNJ)

21 **Identification and Management of Asymptomatic HIV Infection**
12 Noon-1 P.M.—Hospital Center at Orange, Orange
(AMNJ)

27 **Identification and Management of Asymptomatic HIV Infection**
2:30-3:30 P.M.—Ancora Psychiatric Hospital, Hammonton
(AMNJ and NJDOH)

MEDICINE

April

1 **Endocrinology Monthly Meeting**
6-9 P.M.—Holiday Inn, Newark Airport, Newark
(AMNJ)

1 **Endocrinology Grand Rounds**
8 11:30 A.M.-1 P.M.—VA Medical
15 Center, East Orange
22 *(AMNJ)*
29

1 **Interhospital Endocrine**
8 **Rounds**
15 3:30-5:30 P.M.—Newark Beth
22 Israel Medical Center,
29 University Hospital, VA Medical Center, and United Hospitals Medical Center
(AMNJ)

1 **Intensive Review of**
8 **Internal Medicine**
15 4-7 P.M.—University Hospital,
22 Medical Education Bldg.,
29 New Brunswick
(UMDNJ and AMNJ)

1 **Malpractice Insurance Crisis**
10:30-11:30 A.M.—Christ Hospital, Jersey City
(AMNJ)

3 **Down's Syndrome Conference**
8:30 A.M.-2:30 P.M.—Morristown Memorial Hospital, Morristown
(AMNJ)

7- **Annual Orthopaedic Spring**
12 **Meeting**
9 A.M-1 P.M.—Grand Cayman Islands
(NJ Orthopaedic Society)

13 **Diabetic Retinopathy**
1-2 P.M.—New Lisbon Developmental Center, New Lisbon
(AMNJ and NJDOH)

15 **Diabetes-Related Cardiovascular Disease**
10:30-11:30 A.M.—St. Mary's Hospital, Passaic
(AMNJ and NJDOH)

15 **Nutritional Assessment**
10-11 A.M.—Hunterdon Developmental Center, Clinton
(AMNJ)

15 **26th Annual William P. Burpeau Award Dinner: Practical Urodynamics**
7-10 P.M.—The Manor, West Orange
(AMNJ)

21 **Role of Urea Kinetic Modeling in the Management of Dialysis Patients**
7:30-9:30 P.M.—Overlook Hospital, Summit
(AMNJ)

22 **Annual Spring Conference: Association for Hospital Medical Education**
All day—MSNJ Headquarters, Lawrenceville
(Assoc. for Hospital Medical Education and AMNJ)

24 **Current Concepts in Neonatal Hematology**
8 A.M.-5 P.M.—Hyatt Regency, New Brunswick
(AMNJ and The Valerie Fund)

24 **Priority Prevention: Annual Conference**
9 A.M.-5 P.M.—Holiday Inn, Jamesburg
(New Jersey Coalition for Prevention of Developmental Disabilities)

29 **Sleep Disorders**
12 Noon-5 P.M.—Mercer Medical Center, Trenton
(AMNJ)

May

1 **Diabetic Nephropathy**
8:30-9:30 A.M.—Chilton Memorial Hospital, Pompton Plains
(AMNJ)

5 **Diabetic Retinopathy**
10:30-11:30 A.M.—St. Mary's Hospital, Passaic
(AMNJ)

6 **Endocrinology Monthly Meeting**
6-9 P.M.—Holiday Inn, Newark Airport, Newark
(AMNJ)

6 **Endocrinology Grand Rounds**
13 11:30 A.M.-1 P.M.—VA Medical
20 Center, East Orange
27 *(AMNJ)*

6 **Interhospital Endocrine**
13 **Rounds**
20 3:30-5:30 P.M.—Newark Beth
27 Israel Medical Center, University Hospital, VA Medical Center, and United Hospitals Medical Center
(AMNJ)

6 **Intensive Review of Internal**
13 **Medicine**
20 4-7 P.M.—University Hospital, Medical Education Building, New Brunswick
(UMDNJ and AMNJ)

6 **National Health Objectives Year 2000**
10:30-11:30 A.M.—Christ Hospital, Jersey City
(AMNJ)

6 **Physician Office Laboratory Workshop**
All day—Center for Health Affairs, Princeton
(ASCP)

7- **Women and Children:**
9 **Preventive Medicine III**
All day—Trump Regency, Atlantic City
(Cooper Hospital/University Medical Center)

11 **Alzheimer's Disease**
1-2 P.M.—New Lisbon Developmental Center, New Lisbon
(AMNJ)

13 **Diabetic Retinopathy**
10:30-11:30 A.M.—St. Mary's Hospital, Passaic
(AMNJ and NJDOH)

13- **Annual Scientific Meeting:**

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Wednesday, April 1, 1992

Thrombolytic Therapy in Myocardial Infarction—1992

Moderator: Ami E. Iskandrian, M.D.

3:00-3:25 Streptokinase, t-PA, anistreplase: Drug selection and changing criteria for patient selection—***Bernard L. Segal, M.D.***

3:25-4:05 Management of patients with acute myocardial infarction after thrombolytic therapy: Infarct sizing, assessment of results, detection of ischemia—***Mario Verani, M.D., Director of Nuclear Cardiology; Professor of Medicine, Baylor College of Medicine***

4:05-5:00 Case Presentations—***Joseph Lemlek, D.O.***
Panel Discussion—***Jaekyeong Heo, M.D., Ancil A. Jones, M.D., J. David Ogilby, M.D.***

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15 **Emergency Medicine**
Trump Plaza, Atlantic City
(American College of Emergency Physicians and AMNJ)

19 **Medical Problems in the Elderly**
11 A.M.-12 Noon—Human Resource Development
Institute, MSNJ Headquarters, Lawrenceville
(AMNJ)

19 **General Membership Meeting**
All day—Ramada Inn, Clark
(NJ State Society of Anesthesiologists)

20 **QA Criteria Development**
10:30-11:30 A.M.—St. Mary's Hospital, Passaic
(AMNJ)

21-22 **Pediatric Life Support**
8 A.M-4 P.M.—UMDNJ-Medical Science Building, Newark
(UMDNJ)

ONCOLOGY

April

16 **Tumor Board Conference**
12:15-1:15 P.M.—Mercer Medical Center, Trenton
(Mercer Medical Center)

23 **Cocktail Reception**
6:30-9 P.M.—Hyatt Regency, New Brunswick
(Head and Neck Oncology Section, AMNJ)

May

13 **Joint Meeting: Head and Neck Oncology Section and Radiation Oncology Section**
6:30-9 P.M.—The Manor, West Orange
(AMNJ)

21 **Tumor Board Conference**
12:15-1:15 P.M.—Mercer Medical Center, Trenton
(Mercer Medical Center)

PSYCHIATRY

April

15 **Medical and Psychiatric Aspects of Drug and Alcohol Abuse**
2:30-3:30 P.M.—Ancora Psychiatric Hospital, Hammonton
(AMNJ)

29 **Men in the 90s: Challenge and Opportunity—A Mental Health Perspective**
All day—Carrier Foundation, Belle Mead
(Carrier Foundation)

May

7 **How to Handle Treatment Resistant Depression**
1:30-2:30 P.M.—Essex County Hospital Center, Cedar Grove
(AMNJ)

28 **Aggressive and Self-Destructive Behavior**
1:30-2:30 P.M.—Essex County Hospital Center, Cedar Grove
(AMNJ)

RADIOLOGY

April

16 **Radiology Lecture**
1:30-5 P.M.—Saint Barnabas Medical Center, Livingston
(Saint Barnabas Medical Center)

16 **MRI Conference and Case Presentation**
7:30-9:30 P.M.—Saint Barnabas Medical Center, Livingston
(NJ Institute of Ultrasound in Medicine, Radiological Society of New Jersey, and Diagnostic Radiology Section, AMNJ)

May

21 **Radiology Lecture**
1:30-5 P.M.—Saint Barnabas Medical Center, Livingston
(Saint Barnabas Medical Center)

21 **MRI Conference and Case Presentation**
7:30-9:30 P.M.—Saint Barnabas Medical Center, Livingston
(Radiological Society of New Jersey and Diagnostic Radiology Section, AMNJ)

SURGERY AND ITS SPECIALTIES

April

4 **Annual Meeting**
9 A.M-1 P.M.—Nassau Inn, Princeton
(NJ Society of Plastic and Reconstructive Surgeons)

8 **New Wrinkles in Facial Cosmetic Surgery**
10:30-11:30 A.M.—St. Mary's Hospital, Passaic
(AMNJ)

IN MEMORIAM

BARRY R. AIKEY

We regret to announce the death of Barry Ray Aikey, MD, at the untimely age of 55. Born in Bellefonte, Pennsylvania, on September 7, 1936, Dr. Aikey died on December 13, 1991. Dr. Aikey was awarded a medical degree from Jefferson Medical College, Philadelphia, in 1962. He completed an internship at Methodist Hospital, Philadelphia, in 1963; a residency at Jefferson Medical College Hospital, Philadelphia, in 1969; and a fellowship at Jefferson Medical College, in 1970. A pathologist, Dr. Aikey practiced in Atlantic City and Camden. He was affiliated with Our Lady of Lourdes Medical Center, Camden, and was an instructor at Jefferson Medical College. He was a member of our Camden County component and of the American Medical Association, and a diplomate of the American Board of Clinical Pathology and of the American Board of Dermatopathology. Dr. Aikey resided in Philadelphia and Camden. He served two years in the United States Navy as a ship physician.

IRVING BAER

Retired for ten years, Irving Baer, MD, of Toms River, died on October 6, 1991. He was born in Bayonne on November 12, 1915. Dr. Baer was awarded a medical degree from Tulane University School of Medicine, New Orleans, in 1938. He received his New Jersey medical license in 1944. Dr. Baer, a dermatologist, practiced in Toms River, Neptune, and Red Bank. In 1985, Dr. Baer was awarded the MSNJ Golden Merit Award for 50 years of service to the medical community. In addition to his many years of medical service, Dr. Baer was a member of our Monmouth County component and of the American Medical Association; a diplomate of the American Board of Dermatology; a fellow of the American Academy of Dermatology; and a staff physician at Monmouth Medical Center, Long Branch, Fitkin Memorial Hospital, Neptune, and Riverview Medical Center, Red Bank. Dr. Baer was a United States Army Medical Corps veteran of World War II.

JOSEPH C. BORRUS

Born on December 30, 1916, in Brooklyn, New York, Joseph Cavitt Borrus, MD, passed away on November 11, 1991. He was 74 years old. Dr. Borrus attended Boston University School of Medicine, Massachusetts, and was awarded a medical degree in 1943. A neuropsychiatrist, Dr. Borrus practiced in New Brunswick. His medical career included: chief of psychiatry at St. Peter's Medical Center, New Brunswick; attending at Robert Wood Johnson University Hospital, New Brunswick, and John F. Kennedy Medical Center, Edison; associate clinical professor at the University of Medicine and Dentistry of New Jersey-Robert Wood Johnson Medical School, Piscataway; a member of our Middlesex County component, of the American Medical Association, of the New Jersey Psychiatric Association, and of the Multiple Sclerosis Society; a diplomate of the American College of Psychiatry; and a fellow of the American Psychiatric Association. During World War II, Dr. Borrus served in the United States Army Medical Corps. He resided in Newark and Edison.

NICHOLAS A. FALCONE

A member of our Somerset County component, Nicholas Angelo Falcone, MD, passed away on September 9, 1991, at the age of 82. Dr. Falcone was born in Roseto, Pennsylvania, on February 5, 1909. He attended Jefferson Medical College, Philadelphia, and was awarded a medical degree in 1934. The following year, Dr. Falcone received his New Jersey medical license. A general practitioner, Dr. Falcone practiced in North Plainfield and was affiliated with Muhlenberg Hospital, Plainfield. Dr. Falcone was a member of the American Medical Association. He was a captain in the military during World War II. Dr. Falcone resided in Plainfield.

EDWARD D. FENIMORE

Eighty-one-year-old Edward David Fenimore, MD, of Tinton Falls, passed away on December 3, 1991. He was born in Jersey City on May 30, 1910, and graduated New York Medical College Flower and Fifth Avenue Hospital, New York, in 1934. The following year, he received his New Jersey medical license. A general practitioner, Dr. Fenimore practiced in Jersey City. He was director of obstetrics, president of the medical staff, and chairman of the executive committee at Christ Hospital, Jersey City. Dr. Fenimore was a member of our Hudson County component and of the American Medical Association, and a fellow of the American College of Obstetricians and Gynecologists. During World War II, Dr. Fenimore was a major in the United States Air Force. Formerly, Dr. Fenimore resided in Jersey City.

JOHN C. FROMMELT

Pompton Lakes resident John Calvin Frommelt, MD, died on December 13, 1991, at the age of 66. Dr. Frommelt was born in Totowa on February 11, 1925. In 1950, Dr. Frommelt was awarded a medical degree from Jefferson Medical College, Philadelphia. The following year, he received his New Jersey medical license. Specializing in obstetrics and gynecology, Dr. Frommelt practiced in Riverdale for 36 years, and was on staff at Paterson General Hospital. He headed the medical staff and the obstetrical department at Chilton Memorial Hospital, Pompton Plains. Dr. Frommelt was a member of our Passiac County component and of the American Medical Association; he was a fellow of the American College of Obstetricians and Gynecologists. Dr. Frommelt served in the United States Navy. Dr. Frommelt also resided in Collingswood.

VINCENT INCECIAN

Born in Istanbul, Turkey, on September 5, 1920, Vincent Incecian, MD, passed away on November 6, 1991. Dr. Incecian was awarded a medical degree from the University of Istanbul, Turkey, in 1945. Dr. Incecian completed an internship in 1945 and a residency in 1956, both at Hackensack Hospital. He received his license to practice medicine in Turkey, New Hampshire, Washington, DC, and New Jersey in 1945, 1956, 1959, and 1959, respectively. Dr. Incecian specialized in obstetrics and gynecology. He practiced in Oradell and was an attending at Pascack Hospital, Westwood. He was a member of our Bergen County component, and a diplomate of the American College of Obstetrics and Gynecology. Dr. Incecian resided in Oradell and retired to Fort Lauderdale, Florida. From 1958 to 1960, Dr. Incecian was a major in the United States Army.

BENJAMIN D. JACOBSON

Eighty-two-year-old Benjamin Dee Jacobson, MD, an obstetrician and gynecologist, passed away on November 12, 1991. Dr. Jacobson was born in New York City on October 16, 1909. In 1937, Dr. Jacobson graduated from Creighton University School of Medicine, Nebraska. The following year he received his New Jersey medical license. He practiced in New Brunswick from 1946 until his retirement in 1976, and was on staff at St. Peter's Medical Center and Middlesex General Hospital, both in New Brunswick, and Roosevelt Hospital, Edison. Dr. Jacobson also was a professor at UMDNJ, Piscataway; a member of our Middlesex County component and of the American Medical Association; a diplomate of the American Board of Obstetrics and Gynecology; and a fellow of the American College of Obstetricians and Gynecologists and of the International College of Surgeons. Dr. Jacobson was a resident of New Brunswick, Highland Park, and Piscataway. Dr. Jacobson served in the European Theater during World War II with the United States Army.

SAMUEL D. KAPLAN

At the grand age of 80, Samuel D. Kaplan, MD, passed away on December 11, 1991. Dr. Kaplan was born in East Orange on June 4, 1911. He attended the University of Pennsylvania School of Medicine, Philadelphia, earning his medical degree in 1936. Dr. Kaplan received his license to practice medicine in New Jersey the following year. A dermatologist, Dr. Kaplan practiced in Elizabeth; he was affiliated with Elizabeth General Medical Center, St. Elizabeth Hospital, and Alexian Brothers Hospital, all in Elizabeth; Newark Beth Israel Medical Center; and Saint Michael's Medical Center, Newark. Dr. Kaplan was a member of our Union County component, of the American Medical Association, and of the New Jersey Dermatological Society; a diplomate of the American Board of Dermatology; and a fellow of the American Academy of Dermatology. Dr. Kaplan served in the United States Army during World War II.

BERNARD B. LILIEN

Chief of the Department of Pediatrics at Irvington General Hospital from 1963 to 1983, Bernard Banner Lilien, MD, died on October 30, 1991. He was 82 years old. Dr. Lilien was born in Newark on November 22, 1908; he resided in Irvington and Maplewood. He attended the State University of Iowa College of Medicine, Iowa City, graduating in 1933. Dr. Lilien completed an internship at Elizabeth General Medical Center and a residency at Iowa City Pediatrics Hospital. He received his New Jersey medical license in 1936. Dr. Lilien maintained a pediatrics practice in Irvington for 47 years. He also was head of the pediatrics outpatient services at Irvington General Hospital; a public health officer for Irvington; a physician for the Irvington and Maplewood public school systems; and a staff member at Newark Beth Israel Medical Center and Saint Barnabas Medical Center, Livingston. Dr. Lilien was a member of our Essex County component and of the American Medical Association, and a diplomate of the American Board of Pediatrics. During World War II, Dr. Lilien was a major in the United States military.

ANTHONY F. PALMERI

Anthony Francis Palmeri, MD, of Clifton, was born in Passaic on January 24, 1917, and died on November 16, 1991, at the age of

74. After receiving a medical degree from Georgetown University, Washington, DC, in 1942, Dr. Palmeri served in the United States Army with the 51st Field Army Hospital. He was awarded five battle stars and a presidential citation. Dr. Palmeri also completed postgraduate work at New York University, New York. He completed internships at Jersey City Medical Center and St. Mary's Hospital, Passaic, and a residency at the former Margaret Hague Maternity Hospital, Jersey City. In 1947, Dr. Palmeri began a practice in Clifton. Dr. Palmeri's medical career included: chief of obstetrics and gynecology at St. Mary's Hospital, Passaic; vice-chairman of St. Mary's Hospital executive board and vice-president of the hospital's medical board; and instructor at UMDNJ and Seton Hall Medical School, South Orange. Dr. Palmeri was a member of our Passaic County component, of the Passaic-Bergen chapter of the New Jersey Association for Retarded Citizens, and of the Academy of Medicine of New Jersey; and a fellow of the International College of Surgeons and of the American College of Obstetrics and Gynecologists. Dr. Palmeri was a gynecologist.

HUGH A. SCALA

Born in Jersey City on November 15, 1910, Jersey City resident Hugh Albert Scala, MD, passed away on November 11, 1991, at the grand age of 80. Dr. Scala attended the Faculty of Medicine University of Rome and was awarded a medical degree in 1940. Dr. Scala maintained a practice in Jersey City; he was director of emergency services at St. Francis Hospital, Jersey City, and on staff at Jersey City Medical Center. He was a recipient of the Medical Society of New Jersey Golden Merit Award for 50 years of medical service. Dr. Scala was a member of our Hudson County component and of the American Medical Association. Retired since 1975, Dr. Scala was a family practitioner.

CHARLES H. SMITH

At the grand age of 78, Charles Hodges Smith, MD, died on September 30, 1991. Dr. Smith was born on November 27, 1912, in Clifton; he was awarded a medical degree from Temple University Medical School, Philadelphia, in 1940. The following year, Dr. Smith received his New Jersey medical license. Dr. Smith served in the United States Navy during World War II from 1943 to 1946. A physician for 50 years, Dr. Smith practiced in Glen Ridge, and was affiliated with The Mountainside Hospital, Montclair, and Community Memorial Hospital, Toms River. Dr. Smith was an internist and general surgeon. He resided in Glen Ridge. Dr. Smith was a member of our Essex County component and of the American Medical Association.

HOWARD P. SNYDER

Ophthalmologist Howard Percival Snyder, a Westfield resident, passed away on November 21, 1991, at the grand age of 84. Dr. Snyder was born in Somerville on June 16, 1907. He was awarded a medical degree from McGill University, Montreal, Canada, in 1938. Dr. Snyder received his New Jersey medical license the following year. Dr. Snyder practiced in Westfield and was affiliated with Newark Eye and Ear Infirmary, Rahway Hospital, and Muhlenberg Hospital. Dr. Snyder was a member of our Union County component, of the Academy of Medicine of New Jersey, and of the New Jersey Ophthalmological Society. Dr. Snyder retired in 1987. Dr. Snyder lived in Scotch Plains, Fanwood, and Westfield.

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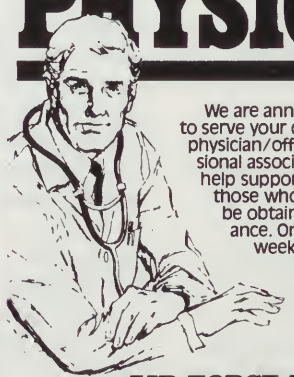
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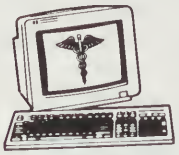
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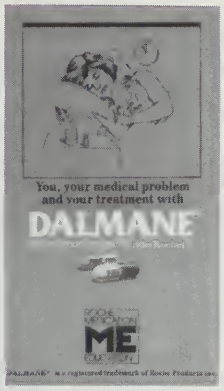
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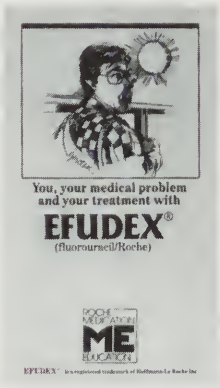
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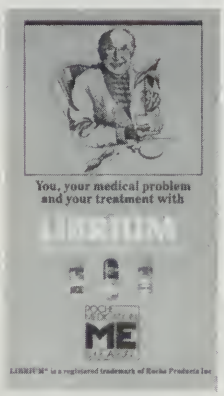


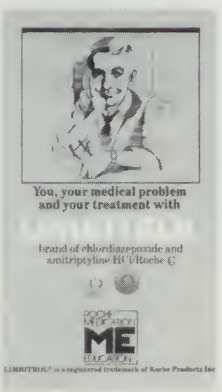
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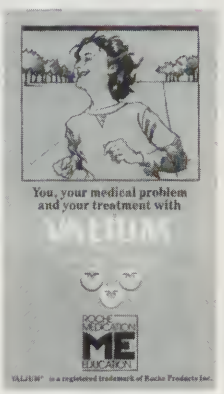
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NEW JERSEY MEDICINE

April 1992

THE JOURNAL OF THE MEDICAL SOCIETY OF NEW JERSEY



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Newswatch

A SPECIAL MESSAGE FROM JOE RIGGS...

My friends, on the night of March 8, 1992, a prominent New Jersey physician, Richard L. Levine, MD, died in his car, outside Princeton, possibly as a result of cocaine abuse.

This tragedy must awaken a shared commitment to fight substance abuse among us. Please read on.

Under the Medical Conduct Reform Act of 1990, New Jersey physicians are required to report practitioner impairments to proper authorities. More profound than this legal obligation, however, is our ethical responsibility. Silence and acquiescence to denials of disease are indefensible.

As doctors of medicine, we know the signs and symptoms of chemical abuse, alcoholism, and addiction. We know the effects that imperil the user, the family, and the user's unwitting patients. Fortunately, we in New Jersey have access to the Physicians' Health Program of the Medical Society of New Jersey. Under the highly skilled and discreet directorship of David I. Canavan, MD, the Program has achieved exemplary success. Since 1982, 83 percent of the approximately 500 chemically dependent physicians enrolled in the Program have maintained continuous abstinence.

Dr. Canavan and his colleagues, Reverend Ed Reading and Sam Trock, MD, confront and/or assist any physician who is referred by colleagues, by himself, by family members, by the State Board of Medical Examiners, and by other sources. As the motto of the Program reminds us, referral is "an act of love."

The Physicians' Health Program can be contacted confidentially by telephone at 1/609/896-1766, extension 1, during business hours. If you, or a colleague, suffers from a substance abuse problem, please call now. For yourself. For all of us. For the patients. For Richard Levine.

STATE HEALTH PLAN...

The Medical Society of New Jersey (MSNJ) has testified before a number of legislative hearings and the Health Care Administration Board regarding the controversial State Health Plan. MSNJ testimony has included the following:

1. To repeal the $225 million annual cap on capital expenditures.

2. To place four legislators on the State Health Planning Board and the Health Care Administration Board.

3. To postpone implementation until January 1, 1993.

4. To refer the Plan back to the local advisory boards for review and comment.

5. To revise the Health Care Trust Fund to establish a board of trustees.

6. To repeal the current 0.53 percent surtax on hospitals.

7. To repeal the certificate of need requirement on physicians and hospitals.

The Legislature is expected to act quickly to slow down the process that is being steamrolled by the New Jersey State Department of Health.

April 1992

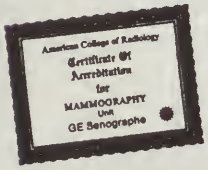
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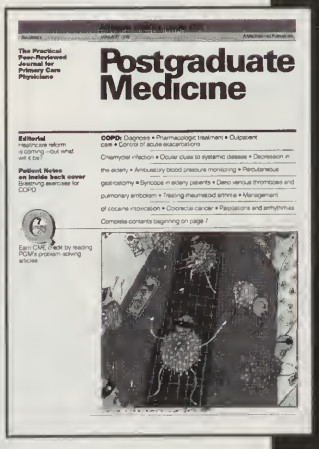
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Drs. Corsan and Kemmann discuss the GIFT procedure used in the treatment of infertility. Cover: Williams & Philips.

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Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalmic centers and release of posterior pituitary hormone.

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References:

1. A. Morales et al., New England Journal of Medicine 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical Letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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MSNJ NEWSLETTER

LOCUM TENENS OPPORTUNITIES

The American Medical Association (AMA) is offering a service for physicians looking for short-term positions and for practices recruiting temporary replacements. The AMA's Locum Tenens Service provides recruiters and physicians with the widest possible exposure through listing locum tenens positions in the AMA's *Opportunity Placement Register* and with abbreviated curricula vitae of physicians in the AMA's *Physician Placement Register.* A complete physician curricula vitae can be ordered through the Service by practices seeking locum tenens physicians. Physicians also can request profiles of practices offering locum tenens positions.

For more information about the AMA's Locum Tenens Service, contact AMA's Physicians Career Resource, American Medical Association, P.O. Box 10012, Chicago, IL 60610, or call 1/800/955-3565.

VISIT RUSSIA WITH MEDICAL EXCHANGE

Twenty-four medical professionals, recruited by The Transnational Institute of Norwich, Vermont, will visit Moscow from September 15 to 26, 1992. They will live and work with professional colleagues in Moscow. A delegation of medical professionals from Moscow is expected to visit the United States in spring 1993.

Participants are being sought from these specialties: general practice, surgery, endocrinology, and radiation injury treatment. The total cost of participation is $2,700. This project gives interested medical professionals the opportunity for a professional and personal encounter with the "new" Russia.

For further information about the exchange program, contact: The Transnational Institute, Box 710, Norwich, VT 05055.

DIABETES DISASTER PLAN GUIDELINES

The Garden State Association of Diabetes Educators has developed general guidelines to educate patients with diabetes on natural disaster preparedness. Storage of insulin, access to medical care and supplies, and sample press releases for the diabetes educator are some of the topics included in the guidelines. Copies of "Diabetes Disaster Plan Guidelines for New Jersey" are available for $5 from: Garden State Association of Diabetes Educators, Marlene Russell, Executive Director, 472 Elmwood Avenue, Maplewood, NJ 07040.

DEBT COLLECTION

Are you having difficulty with accounts receivable? That is not surprising in today's weak economy. The recession has left red ink stains on many businesses' books as overdue bills go unpaid. Moreover, our stagnant economy does not show many signs of coming to life soon.

Although you might think collection agencies are swamped in recessionary times like this, the agency that MSNJ endorses says that this is not true. According to I.C. System, Inc., creditors tend to retain bills longer before submitting them, because they want to try collecting the delinquent

accounts themselves. Unfortunately, this rarely works. If a debtor has not paid after 90 days, there is little likelihood he ever will pay without the help of a third party. According to the American Collectors Association, only 5 percent of accounts over 90 days delinquent are paid voluntarily. This is where I.C. System's assistance can be invaluable. The sooner you submit your accounts to I.C. System, Inc., the more successful you will be in collecting money.

There is another urgent reason for sending your delinquent accounts to I.C. System, Inc. immediately: tax refunds. Your debtors may be receiving tax refund checks from federal and state governments. If your accounts are being actively collected when the refund money arrives, I.C. System, Inc. may be able to settle many of your past-due accounts.

To take advantage of tax time, I.C. System, Inc. strongly recommends that you gather your overdue accounts and submit them for collection as soon as possible. Make it a practice to turn in all accounts regularly once they become 60 to 90 days delinquent. As accounts age, they become less collectable. Delaying submission longer than 90 days quickly reduces the value of debts, as much as one-half of a percent a day.

I.C. System, Inc. was established in 1938 and serves clients in all 50 states. If you are not currently using I.C. System, Inc. services, you can obtain more information by calling I.C. System, Inc. at 1/800/325-6884.

NATIONAL ORGAN DONOR CAMPAIGN

In an effort to close the growing gap between the thousands of people waiting for a life-saving transplant and those would-be organ donors, the Association of Organ Procurement Organizations, Inc. (AOPO) has instituted a national public education campaign aimed at relieving public fears and encouraging more people to donate organs after death. The campaign includes colorful brochures, donor cards, posters, and billboards, incorporating the slogan, "Be an organ donor . . . it's the chance of a lifetime." To receive a free brochure and donor card, contact the Association of Organ Procurement Organization at 1/202/466-4353, or the New Jersey Organ And Tissue Sharing Network (The Sharing Network) at 1/201/379-4535.

NATIONAL HEALTH CARE

Nine out of ten Americans want health care reform, but they doubt a government-run system would meet the four criteria they deem important to a successful health care system—increased access, reduced cost, high quality, and freedom of choice, stated a poll released by the Aetna Insurance Co.

TAX DEDUCTION?

Allowing a federal income tax deduction for the cost of health care insurance would reduce the number of Americans without any health insurance by as much as 9.8 million, according to a study released by a new nonprofit research group, Health Care Solutions for America.

SOLVING MALPRACTICE CLAIMS

Fifteen states allow arbitration to be used to solve medical malpractice claims, but only 1 state—Michigan—has a program assuring this alternative to the court system is offered to patients, the General Accounting Office said in a report to Congress.

POL WORKSHOPS

The key to quality testing in physician office laboratories is education. There will be a program on hematology testing and immunologic testing for physician office laboratory personnel and physicians on May 20, 1992. In addition, there will be a Red Cross cardiopulmonary resuscitation class during the day. For further information on this and other programs, please contact Ms. Kathleen Voldish, New Jersey State Advisor, American Society of Clinical Pathologists, 1/609/428-7652.

CANADIAN HEALTH CARE

Instituting a Canadian-style health care system in the United States would cost American taxpayers as much as $81.5 billion annually, the Republican staff of the Joint Economic Committee asserted in a report and discussed by Representative Richard Armey (R-Texas).

CONGRATULATIONS TO MSNJ

The Medical Society of New Jersey (MSNJ) was honored by the American Medical Association (AMA) at the 1992 AMA National Leadership Conference. MSNJ increased AMA dues-paying membership for 1991. Accepting the plaque for MSNJ is President Joseph Riggs, MD (third from left). He was congratulated by Palma E. Formica, MD, a member of the AMA Board of Trustees; Joseph T. Painter, MD, chairman, AMA Board of Trustees; and Mrs. Painter.



SLEEP DISORDERS

Mercer's Sleep Disorders Center in conjunction with the Academy of Medicine of New Jersey is sponsoring a conference, "Sleep Disorders: Recognition, Evaluation, and Treatment." The conference will be held on April 29, 1992, from 1:00 to 5:00 P.M. The program is designed for family practitioners, internists, and other primary care physicians. The program also has been reviewed and is acceptable for 3.75 prescribed hours by the American Academy of Family Physicians. Preregistration through the Academy of Medicine of New Jersey is required along with a $50 registration fee. For additional information and registration contact: Joyce Fleming, Academy of Medicine of New Jersey, 1/609/896-1717.

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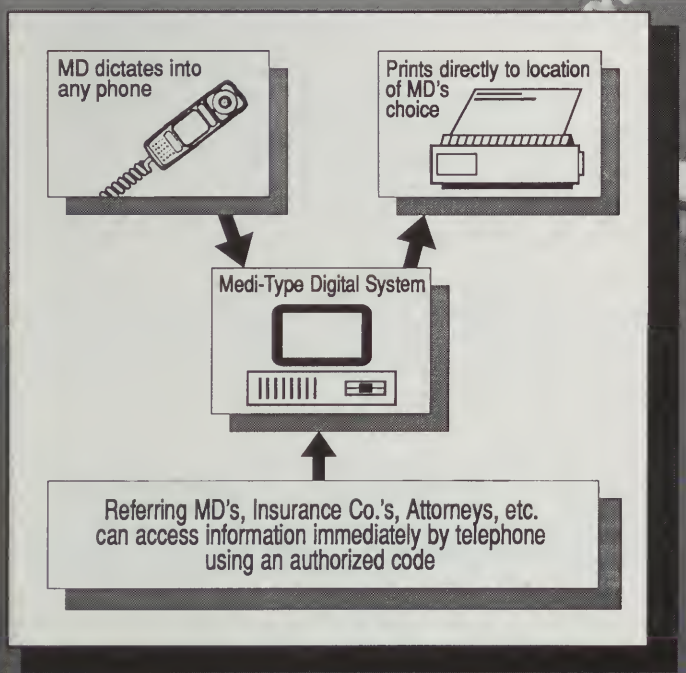
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PROFESSIONAL LIABILITY

HEALTH CARE FINANCING

The President's Plan. President Bush's "Comprehensive Health Reform Program" was released on February 6, 1992. The plan includes a tax credit or deduction for health insurance costs up to $1,250 for individuals and $3,750 for families, with income limits of $50,000 for single persons and $80,000 for married persons filing jointly. Self-employed persons could deduct 100 percent of their insurance premiums.

Other provisions of President Bush's plan would require health insurers to insure all groups and to eliminate pre-existing conditions that limit benefits for new employees. The plan would set up health insurance networks, so combinations of small firms could purchase insurance at reasonable rates. Large differences in premiums among groups would be phased out.

In addition, the President proposes that states adopt several tort reforms: eliminating joint and several liability, and placing a cap on awards for pain and suffering; prohibiting double recovery; structuring awards to reduce jury discretion; promoting pretrial alternatives; and improvements in quality of care.

States that fail to adopt such reforms would lose certain federal funds.

HCFA Budget. In his annual budget message, the President proposed a 12 percent increase in expenditures by the Health Care Financing Administration (HCFA) for reimbursement and operations under Medicare and Medicaid. In fiscal year 1993 these expenditures would reach $213.7 billion.

National Health Insurance (NHI) Means Lower Expenditures. A study supported by The Robert Wood Johnson Foundation in Princeton says that a system of national health insurance, with firm controls on expenditures, could save up to $4.3 trillion over ten years and end the problem of uninsured patients. A report by the Washington, DC-based Economic and Social Research Institute backs efforts to recast the United States health care system on either the Canadian model, with national health insurance administered through provinces, or the German model, with national health insurance administered through private "sickness funds."

The authors note that Canadian physicians earn about 25 percent less than their stateside counterparts, but have greater practice autonomy and less paperwork. Canadian hospitals, says the report, are staffed at about half the level of United States hospitals. In Canada and Germany, medical associations are involved in fee negotiations.

Also summarized in the report is the UNY-Care proposal developed by former New York State Health Commissioner David Axelrod, MD, in which the state acts as a single payer setting reimbursement levels. (Possibly a similar sort of plan could emerge in New Jersey if Governor Jim Florio is re-elected next year and if Governor Florio's State Health Plan is put in place.) The Consumer Choice Health Plan advocated by professor Alain Enthoven is summarized as well; this plan promotes the use of after-tax dollars by consumers to finance all health care above minimum levels.

NHI Means Long Waits. Another recent report, this one issued by the National Center for Policy Analysis in Dallas, emphasizes how NHI in Canada and other countries generates long queues for treatment. Americans, says the report, are twice as likely as Canadians, and four times as likely as Britons, to receive open heart surgery. It further states that waits for MRI services in Ontario are as long as 16 months.

Moreover, NHI does not remove barriers to care based on income, say the authors. For example, in Britain, underserved areas receive the lowest levels of funding on hospital services. Another failing of a regulated system seen by the authors is inefficiency; one-fourth of British hospital beds are empty while one million people wait for elective surgery, and one-fifth of Canadian beds are empty while 250,000 people await surgery.

California Initiative. The California Medical Association is backing a ballot initiative for the November general election that would require employers to offer health insurance benefits. The mandate would be phased in between 1994 and 1997.

MALPRACTICE AND OTHER CASES

Sex Discrimination. Promotion to full professorial rank and back pay were awarded an associate professor of anatomy at the University of Iowa by a federal judge. The professor claimed sex discrimination under the Civil Rights Act during a 13-year period in which she repeatedly

was accused of a sexual relationship with her department chairman. The alleged abuses include spreading rumors at national meetings and throughout the university, posting graffiti and sexually explicit cartoons, and yelling sexual epithets.

Battery and Informed Consent. The theories of battery and informed consent are "diametrically opposed and mutually inconsistent," a New Jersey Appellate Division court has ruled. In a case involving factual and legal questions about whether a patient with a history of Fallopian tube disease consented to a laparotomy—or instead, as the patient contended, to a laparoscopy—the court upheld a ruling that the plaintiff was not entitled to jury instruction on informed consent.

In informed consent actions, stated the court, the plaintiff must prove negligence, typically through expert evidence, and damages are based on the difference between the actual result and the result that would have occurred if proper information had been furnished to the patient. By contrast, battery is an intentional tort and involves performing an operation without the patient's consent, regardless of whether a favorable medical outcome resulted.

Government Immunity. In another Appellate Division case, reported nationally, government immunity was allowed as a basis for summary judgment for the defense in a case involving injuries from an attack by a patient in a locked unit of a state psychiatric hospital on a voluntarily committed patient. State law shields public entities and employees from liability for injuries "caused by any person who has been confined for mental illness . . . upon any other person so confined." *N.J.S.A. 59:6-7.* Even though the victimized patient committed himself to the unit, he was still "confined" within the meaning of the law, said the court.

Releasing Peer Review Records in New York. A trial judge in New York has denied a state investigative agency access to quality assurance and peer review records on a particular physician. The New York State Health Department's Office of Professional Medical Conduct has demanded the records, noting that the Department has access to such records under state law. But, the court agreed with the hospital involved that the Department's access was not for the purpose of investigating individual physicians.

Corporate Negligence in Pennsylvania. The Keystone State's Supreme Court has adopted the theory of corporate liability for hospitals. In a case involving a patient's complete left-side paralysis in the wake of diagnostic and treatment services at the hands of a hospital staff's general practitioner, cardiologist, general surgeon, and ophthalmologist, the state high court afforded the plaintiff an opportunity to prove at trial that the hospital and its personnel were negligent in not adequately managing the patient's care.

The patient had presented at the hospital's emergency department with injuries from an automobile accident and a history of cardiac problems that her husband related to emergency department personnel. She was admitted for four days, during which neurologic deficits progressed. Following transfer to another hospital, she was diagnosed with a large intracerebral hematoma in the right frontal, temporal, and parietal lobes.

MALPRACTICE VERDICTS

Emergency Physician Death. Apparently as a result of either asthma or an allergic response to a cat, a 33-year-old emergency physician experienced an anaphylactic reaction while on duty in a hospital emergency department in New Jersey. He walked to the respiratory therapy department requesting that epinephrine be administered.

Accepting the physician's request at face value, nurses in the respiratory unit failed to summon another emergency physician. The epinephrine failed, and another emergency physician intervened upon seeing the physician being returned to the emergency room on a stretcher. The intervening physician unsuccessfully attempted intubation and then created a cricothyrotomy. Allegedly as a result of misplacement or a failure to adjust the tube attached to the cricothyrotomy bag, air could not be forced through the bag. By the time a third emergency physician was able to intubate the physician five minutes later, brain death had occurred.

In defense, the intervening physican contended that extensive edema caused by the anaphylactoid reaction prevented him from accomplishing intubation, but subsided in response to medication before the third physician succeeded. Contemporaneous record did not note edema, although a note written several days later did.

Both the intervening physician and the hospital were found not negligent by a jury.

Failure To Order CT Scan. An emergency department physician in New Jersey was found negligent for failing to order a computed tomography (CT) scan for a 38-year-old patient who presented with a laceration in the rear of his skull and signs of being extremely inebriated, including vomiting and not cooperating. Permanent brain damage, including severe impairment of short-term memory, allegedly resulted from a failure to evacuate a subdural hematoma in a timely manner.

A jury found the physican negligent, cleared the physician who first examined the patient, and awarded $1,885,000. The de-

fendant came on duty at a change of shift 35 minutes after the patient's arrival. Costs of institutionalizing the patient were estimated at $120,000 per year.

Physical Restraints. A private physician in the emergency department of a New Jersey hospital was found negligent for failing to order restraints for an 87-year-old nursing home patient with a history of disorientation who was admitted to the department for x-rays following a fall. The patient was placed on a stretcher and the side rails were elevated, but she slipped off the end of the stretcher and suffered a fractured pelvis. Eighteen months later, she died from unrelated causes. The amount of the award was $75,000.

Anticipating a Large Fetus. A brachial plexus injury that resulted in Erb's palsy occurred on delivery following traction on the baby's head before the shoulders were released. The plaintiff alleged that an enlarged uterus, excessive weight gain of the mother, and the previous birth of a macrosomic baby should have alerted the defendant obstetrician to the risk of shoulder dystocia, and that the physician lost composure during the delivery.

The physician countered that the traction used was gentle and that he successfully avoided brain damage during an emergency situation. By the 5-1 vote of a New Jersey jury, the plaintiff won, and was awarded $600,000.

Hysterectomy. According to the plaintiff in this New Jersey case, her gynecologist failed to perform an adequate workup to determine the causes of incontinence, and vaginal bleeding and pain, and then failed to advise her of treatment alternatives before performing a hysterectomy that led to an extended hospitalization for femoral neuropathy and continuing paresthesia.

According to the defendant, the plaintiff chose hysterectomy after being advised of alternatives, saying that her insurance would lapse in two months. The defendant further contended that surgery was warranted, and that records of a second surgical opinion and hospitalization supported his position. He won the case.

Abdominal Catheterization. A $40,000 verdict from a general surgeon was won by a kidney dialysis patient in compensation for two years of pain, swelling, and drainage from an infection that resulted when a portion of a catheter remained after most of the catheter was removed by traction. Eventually, the patient recieved a kidney transplant.

Hand Surgery. After a work-related accident, a patient visited a clinic where a general practitioner noted a laceration to the palm. On a second visit several days later, the patient complained of numbness and tingling. Several months later a neuroma was discovered by the surgeon-owner of the clinic, whose effort at excision did not succeed. The patient claimed that the clinic should have referred him to a hand surgeon or neurosurgeon. He won a $6,000 award from a New Jersey jury for continued numbness and tingling.

LICENSURE

Self-incrimination. Following an alleged hit-and-run accident involving serious injuries, a New Jersey physician was asked by letter to appear at hearings of the State Board of Medical Examiners. Alcohol abuse was suspected. The physician repeatedly declined to exercise his right to counsel. Transcripts of the hearings were admitted in a subsequent criminal bench trial.

Following his conviction for second-degree aggravated assault, the physician claimed before the Appellate Division that admission of the transcripts violated his right against self-incrimination. No, said the court, because the physician had not asserted his Fifth Amendment rights at the hearing, immunity from prosecution was not triggered. Moreover, the trial judge had given the transcripts little weight, because intoxication was immaterial to the criminal charge.

Mandatory Continuing Education. New Jersey is 1 of 22 states that does not require a physician to obtain continuing medical education (CME) as a condition of licensure, according to a recent survey by *Professional Regulation News*. Pennsylvania alone was listed as requiring CME in certain circumstances.

MALPRACTICE POLICY DEVELOPMENTS

Breast Implants. Suits against physicians for silicone breast implants appear to be rare so far, although a Houston plaintiff's attorney is targeting physicians who helped to develop the Dow-Corning product. An award in a California case was $7.3 million, and approximately 800,000 women are said to have received breast implants.

The Tort of Outrage. According to section 46 of the Restatement (2nd) of Torts, liability for severe emotional distress or bodily harm may result from "extreme and outrageous conduct" that is intentionally or recklessly caused. In Arizona a specialist in high-risk obstetrics was found liable under this so-called "tort of outrage" for being absent during a delivery by an intern and third-year resident of a fetus in a double-footing breech. Decapitation occurred, and details were kept from the family.

Film of Victim. To show the extent of injuries resulting from alleged malpractice, a plaintiff's attorney sought to produce a film depicting a day in the life of the child who was injured. At the re-

quest of the defense attorney, the trial court ordered the plaintiff's attorney to provide advance notice of the filming, allow defense counsel to attend the filming, and furnish counsel with a copy of the completed film plus unused footage.

On appeal of the order, the Illinois Supreme Court ruled that such protections are unnecessary. Before a film is shown to a jury, observed the court, a foundation must be laid showing that the film portrays what it purports to portray, and the probative value of the film must be shown to outweigh any prejudicial impact. In this way, the court noted, a film is like a photograph or other demonstrative evidence and does not require special protections.

Loss Ratios Rise. Malpractice insurers appear to be experiencing an increase in loss ratios, according to an analysis performed by Best's and summarized by *Medical Liability Monitor.* In 1990, the reported combined ratio jumped 17 points to 106.

Practitioner Data Bank. From September 1, 1990, to November 22, 1991, the National Practitioner Data Bank received 23,396 reports on physicians and other licensed independent health practitioners. Eighty-five percent of these reports involved malpractice payments, and the remainder involved adverse actions, mostly licensure sanctions.

Proposal for Reform. *Loss Minimizer,* a monthly newsletter written by Californian David Karp, suggests several malpractice reforms that form a potentially salutary package. The suggestions include: certificate of merit, requiring a finding by a licensed medical consultant that a case has medical merit before a malpractice claim can be filed; accreditation of expert witnesses; separate jury proceedings on the amount of damages; and abolition of contingency fees.

AIDS ISSUES

OSHA Rules. As of March, universal precautions must be followed in physicians' offices and other health care settings under new rules of the federal Occupational Safety and Health Administration (OSHA). Violations carry fines up to $70,000. Training of workers is required as of June 1992.

Examples of universal precautions include: proper handwashing technique; gloving, masking, and gowning; vaccinating personnel against hepatitis B; and assuring that personnel with skin abrasions do not have physical contact with patients.

Biting by HIV-Positive Patient. A guard was not warned that a violent hospital patient was HIV positive when the guard was asked to help restrain the patient. The patient responded to the restraint attempt by biting the guard, drawing blood that may have been mixed with the patient's blood. The guard filed a claim based on fear of acquiring AIDS, including emotional distress. At a trial in West Virginia, he was awarded $1.9 million. The award held up on appeal.

PROFESSIONAL LIABILITY

This regular feature of *NEW JERSEY MEDICINE* is authored by James E. George, MD, JD, and Neil E. Weisfeld, JD, MSHyg. Dr. George is director, Professional Liability Control, and Mr. Weisfeld is director, Education, Research & Regulatory Affairs, MSNJ. □



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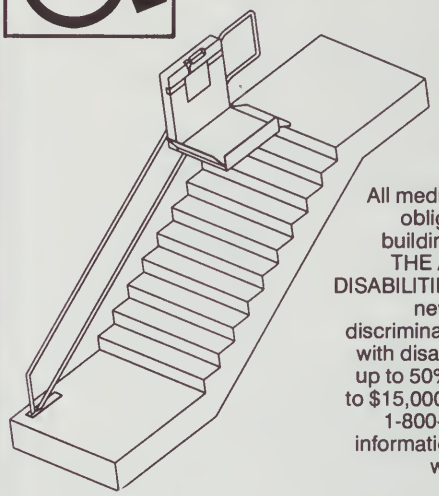
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BOOK REVIEWS

CYTOKINES

M.J. Clemens. Oxford, England, Bios Scientific Publishers, 1991. *Cytokines* is part of the medical perspective series providing current state-of-the-art information on medical immunology. This small text (121 pages) attempts to focus on regulatory proteins known as cytokines. The enormous explosion of information in this area is due to several coinciding developments in cellular and molecular biology including recombinant DNA technology and monoclonal antibodies, and the realization that cytokines control many of the physiological processes implicated in diseases, e.g. cancers, autoimmune disorders, viral infections (including AIDS), and allergic and hypersensitivity reactions that all lead to inflammation. There are six chapters designed to introduce and explain the complicated aspects of cytokine biology—what they are, classification, how they work, networks, their role in health and disease, i.e. wound healing, control of viral infection, and control of hypersensitivity reaction, and their therapeutic uses. I think this book is a "must" for clinical novices, e.g. medical students or clinicians, interested in one of the most fascinating and changing areas of medicine. □ Leonard Bielory, MD

CT AND MR OF THE THORAX

David Naidich; Elias Zerhouni; Stanley Siegelman. New York, NY, Raven Press, 1991. The first edition of this book, *Computed Tomography and Magnetic Resonance of the Thorax,* garnered a standout reputation for its important contribution to the subject of chest computed tomography (CT) scanning interpretation; this second volume promises to do no less. The authors have expanded upon their excellent review of the anatomic and pathologic basis of thorax imaging, to educate the reader in the newest advances to the field. These additions in *CT and MR of the Thorax,* include high-resolution parenchymal scanning and dynamic imaging. The text also considers the practical applications of magnetic resonance (MR), with considerable emphasis placed on flow imaging magnetic resonance imaging (MRI).

Each area of the thorax is systematically examined. The chapter on the mediastinum displays an exceptionally lucid understanding of the congenital anomalies of the great vessels, e.g. right aortic arch anomalies. In this section, the exemplary discussion of CT and MR evaluation of aortic dissection and aneurysm merits special attention. A review of the airways lays a fine groundwork for the ensuing chapters on diseases of the lung parenchyma; these include collapse, focal, and diffuse diseases. CT diagnosis of bronchiectasis, an area for which Dr. Naidich is famous, also is explored. An analysis of the pulmonary hila is performed in a painstakingly clear manner.

Finally, an overview of the heart and pericardium acquaints the reader with the use of such cutting-edge techniques as contrast-enhanced MRI.

The authors convey their mastery of the field in a meticulous, yet accessible fashion. Moreover, the scans are of an unusually high quality. The result, simply, is a superb text. □ Neil B. Horner, MD

NAIL DISORDERS

Robert Baran, MD; Julian Barth; Rodney Dawber. New York, NY, Churchill Livingston, Inc., 1991. This is a hardcover atlas of beautiful color photographs of abnormal digits. Shown are real-life examples of clinical changes in nail configuration, plate structure, color, and periungual tissues. Box listings of differential diagnoses and terse, pertinent clinical comments accompany the illustrations. The emphasis is on recognition and classification. Treatment strategies constitute the final chapter of the book. The few suggested further readings found at the end of each section, rather than extensive references, will have the reader scampering to other textbooks for further details.

Since nail abnormalities frequently are encountered in practice, the textbook should become a well-worn reference in most medical libraries. Dermatologists and podiatrists, particularly those in training, will want to have a personal copy. ☐ Christopher M. Papa, MD

VIOLENCE IN AMERICA. A PUBLIC HEALTH APPROACH

Mark L. Rosenberg; Mary Ann Fenly. New York, NY, Oxford University Press, 1991. The editors of this book have attempted to weave together a collection of articles dealing with violence in America from a public health perspective. The types of violence discussed include the following: assaultive violence; child abuse; child sexual abuse; rape and sexual assault; spouse abuse; violence against the elderly; and suicide. The book describes violence as a problem of monumental proportions in our country in these various manifestations.

The editors urge that funds be allocated to create a more rigorous database for analysis by people in all sectors of society dealing with violence, including professionals from sociology, criminology, economics, law, public policy, psychology, anthropology, and public health. The editors acknowledge that solving the problem of violence will require an interdisciplinary approach. They observe: "To collaborate effectively, these disciplines must agree upon definitions and build compatible data sets. Programs need to be shared, building new bridges with service delivery institutions that are traditionally outside the venue of health agencies, including community-based services like shelters for battered women and rape crisis centers."

An inspirational foreword to this book has been written by C. Everett Koop, MD, ScD, former surgeon general of the United States Public Health Service.

Unfortunately, the material presented throughout the book is very dense with statistical information and the typeface is very small; the book is not "reader friendly."

The title, subject, and intent of the book are admirable. However, its visual presentation and style make it difficult to read. It is more valuable as a resource book for those persons interested in this subject on a research basis. ☐ James E. George, MD, JD

BOOK REVIEWS

Book reviews for *NEW JERSEY MEDICINE* are welcomed by the editor-in-chief. Reviews will be peer reviewed and are subject to editing. Publication will be on a space available basis. Acknowledgement of all reviews will be made, and letters of acceptance will be mailed with notice of publication date. Address letters of inquiry and book reviews to Editor-in-Chief, *NEW JERSEY MEDICINE*, Two Princess Road, Lawrenceville, NJ 08648.

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EDITOR'S DESK

REVOLUTIONARY TIMES

Listen, my children, and you shall hear
Of the midnight ride of Paul Revere,
On the eighteenth of April, in seventy-five,
Hardly a man is now alive
Who remembers that famous day and year.

In April 1992, we could do well to recall the events of past Aprils in our country's history. Two hundred years ago this month the United States Congress authorized the establishment of a mint in Philadelphia, an action needed to insure the financial stability of a new nation. (Compare this action with the present difficulties in the former Soviet Union in creating a universally accepted monetary system, thus adding to the economic woes of those peoples.) During the same month in 1792, President George Washington vetoed a bill dealing with election apportionment, and, in so doing, helped to define the relationship between the executive and legislative branches of our government.

April 14 has been celebrated in Maryland as "John Hanson Day," commemorating the birth, in 1721, of our first president. No, he was not elected by the people under our present constitution. He was elected chairman of the Continental Congress and became the first President of the United States in Congress Assembled in 1781.

The first payment of benefits under the United States Social Security program was made in April 1937, 55 years ago. Who among us could have predicted how that small act would proliferate through the years to the extent seen today, when the entire economy of the country, and certainly that of physicians, is intimately bound to the activities of that program?



Howard D. Slobodien, MD

Fifty years ago, on April 18, 1942, Colonel James Doolittle led his carrier-based bombers on a one-way trip to bomb Tokyo. This raid had much more than propaganda value. After an uninterrupted string of Japanese successes against us, typified by the Japanese signal of Tora, Tora, Tora (Tiger, Tiger, Tiger), after the devastating attack against Pearl Harbor, it also established the United States as a tiger, wounded but aroused and dangerous. (Has today's economic confrontation with Japan similarly aroused us?)

But let us return to April 1775, as described by Henry Wadsworth Longfellow. The midnight ride of Paul Revere actually did not cover that renowned silversmith with glory. The ride was completed by William Dawes, who became a footnote in history. Dawes, a daring cobbler and carpenter, accomplished his task. Revere, by contrast, was captured by the British, interrogated, and released. But his horse was confiscated and he was forced to wend his way homeward on foot.

Regardless of how we consider Paul Revere or William Dawes, the events of that fateful day led to the establishment of the United States of America. Prominent among our founding fathers was the venerable Benjamin Franklin, whose advice at the signing of the Declaration of Independence in 1776 incorporated the theme of this editorial: "We must all hang together, or assuredly we shall all hang separately." The medical profession of today seems to have forgotten this adage.

There always has been competition among physicians. Those in the same specialties felt the heat of legitimate competition. Turf problems caused irritations among those in different disciplines who performed similar procedures, e.g. endoscopy. Residency programs had to develop cooperative programs to allow adequate training. But a collegial spirit pervaded and kept us whole, able to resist external forces threatening the profession. RBRVS has changed that and produced a dog-eat-dog situation.

As soon as the Feds announced that cognitive services might receive increased compensation, perhaps at the expense of procedural services, internists and family practitioners shouted "hurray" and lobbied for its realization. In the face of widespread opposition to "expenditure targets," the prime surgical college in the land announced its intention to accept these targets in return for a better fee schedule for surgeons. In testimony before a congressional committee, radiologists, urologists, and neurologists accused each other of im-

proper and unethical behavior, white-washed themselves, and tarred the entire medical establishment.

Mammon has corrupted us and is making us easy prey to the administrator, the politician, and the bureaucrat—who would enslave us and who, in other countries, forced physicians into unwelcome national health schemes, partly because of the division in medical ranks. We may be prohibited, by current and anti-trust law from properly negotiating financial terms, but we certainly can present a united front on basic principles regarding the welfare of our patients and our citizenry. Napoleon Bonaparte said, "There are only two forces that unite men—fear and interest." He was wrong. We have had fear and more than enough interest (or self-interest), but it has produced disharmony, a lack of cooperation, and a total failure to understand the dangers of splitting the medical profession.

We have forgotten Benjamin Franklin, the Stamp Act, and the Boston Tea Party. It is time we remember. □

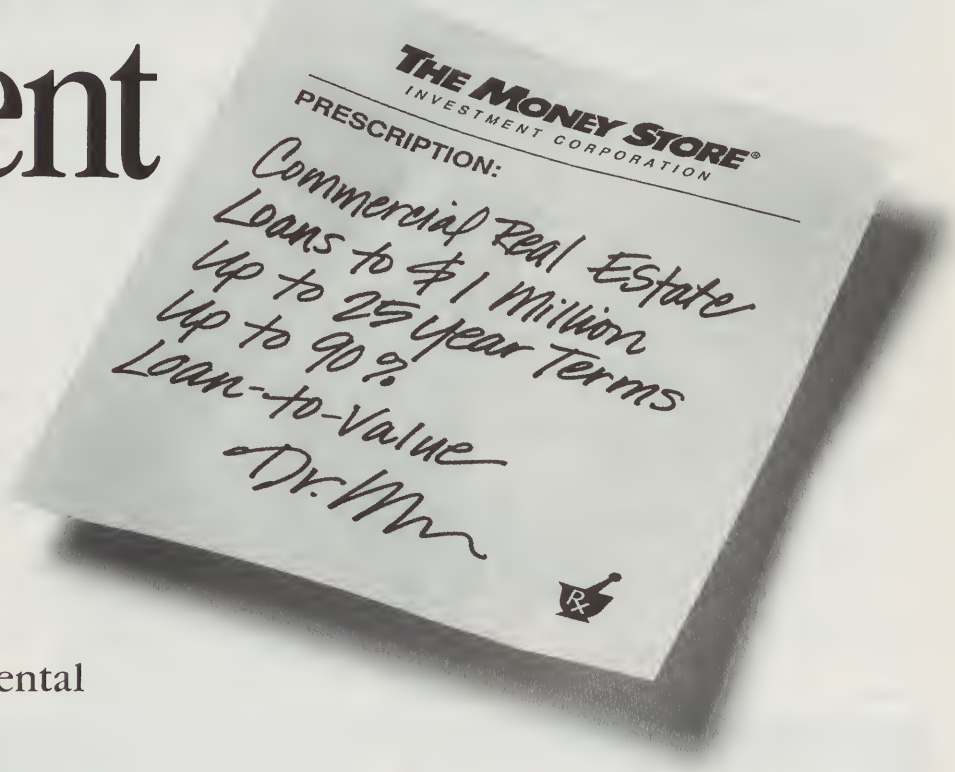
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PRESIDENT 'S PAGE

STATE HEALTH PLAN—COOPERATION NEEDED

Upon taking office one year ago, I hoped that my presidency would be marked by greater cooperation between the state government and the Medical Society of New Jersey (MSNJ). All year, we have opted for a position of accommodation and not necessarily confrontation. There have been some successes in this area:

The New Jersey State Department of Health (NJDOH) has been very responsive to our concerns and interests on AIDS, and we have developed an excellent relationship on AIDS issues with Commissioner Frances J. Dunston and Assistant Commissioner Douglas Morgan.

Our Committee on Environmental Health, led by Dr. Stanley R. Lane, has been working closely with officials of the New Jersey State Department of Environmental Protection and Energy.

Under Dr. Charles Joseph Moloney, our Committee on Public Health has closely monitored and supported NJDOH initiatives to address the new strains of tuberculosis.

On issues relating to international medical graduates (IMGs)—though not yet on issues relating to business practices—the State Board of Medical Examiners has collaborated with our Committee on IMGs, chaired by Dr. Frank Campo, assuring that there is no discrimination.

Efforts to hold a MSNJ-sponsored conference on women and health have been initiated by our Committee on Women in Medicine, including Dr. Leah Ziskin, Acting Deputy Commissioner of Health.

However, on issues of overall health care policy, planning, and financing, we have had little or no



Joseph A. Riggs, MD

cooperation from the state administration. My most profound disappointment in this area relates to one of the most dangerous health schemes to emerge on the state government level—the State Health Plan proposed by the Florio administration.

Many people fail to realize the hazards that are inherent in this proposed State Health Plan. Initially, for example, the Plan received headlines across the state for "regionalizing" child care services in a way that would force 27 hospitals to close their pediatric units. This type of provision horrified pediatricians and family physicians. But, how many other specialties recognize this proposal as the harbinger of what the planners have in store for all specialties?

The proposed Plan also called for the closure of six hospitals in the state. These hospitals were not even advised of this proposal in advance. Their communities were appalled. But, how many other hospital staffs recognize that, under this Plan, from now on all hospitals will be at the mercy of a government-run planning apparatus that can announce closures without warning or consultation?

MSNJ's executive committee has been monitoring State Health Plan developments closely. We have made our views known in aggressive reports, comments, hearings, and news releases. Our work in this area has made our organization the primary source of constructive comments and explanations of the Plan.

To protect your patient's right to first-class medical care, and to protect your right to practice medicine without incessant interference from state government planners, I urge you to make MSNJ's views known to your legislators and to the public. Your county society or MSNJ can help you communicate these opinions effectively.

Simply put, you can help by expressing the following points: physicians and the organizations they represent, must be involved in the planning process; the Plan must not be a cover for giving more power to politicians on the state level; community hospitals need to preserve their unique characteristics and their ability to respond to local conditions.

For those reasons, legislation should be enacted to delay implementation of the Plan for one year, so that an orderly process can be used to develop its key provisions. Physicians have so much to contribute to the development of a sensible, reality-based state health plan. Please speak out, so that our contribution can prove useful. God bless!

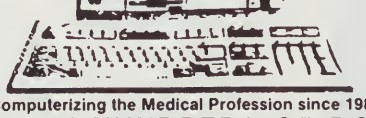
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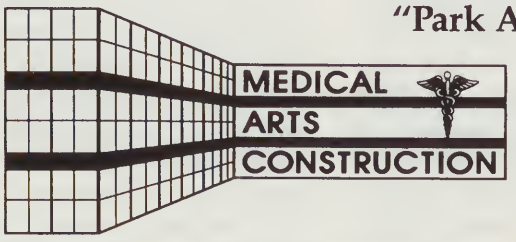
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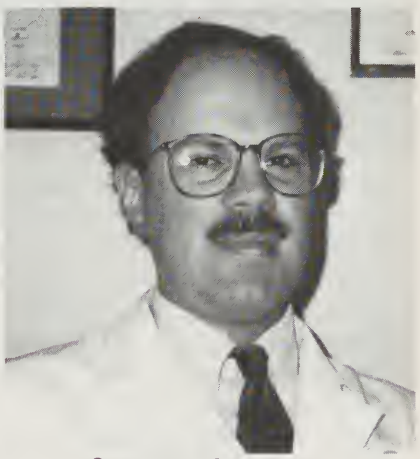
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Gonadotropin-Releasing Hormone Agonist in a GIFT Program

Gregory H. Corsan, MD
Ekkehard Kemmann, MD

The authors describe their experience with the gamete intrafallopian transfer (GIFT) procedure in the treatment of infertility. Utilization of a gonadotropin-releasing hormone agonist resulted in a 51.9 percent clinical pregnancy rate and a low cancellation rate.



Gregory H. Corsan, MD



Ekkehard Kemmann, MD

There are approximately 2.8 million infertile couples in the United States who desire but cannot have children. Although many of these couples will conceive with traditional infertility therapy, some fail to conceive despite our best efforts. Increasingly, these frustrated couples are turning toward more advanced forms of infertility therapy provided through assisted reproductive technologies (ARTs). The best known and most established ART is in vitro fertilization/embryo transfer (IVF-ET or the "test tube baby" procedure). The GIFT procedure (gamete intrafallopian transfer), a spin-off on IVF-ET, also is gaining increasing acceptance.

GIFT, first performed in 1984, refers to a treatment that transfers gametes (eggs and sperm) into the fallopian tube(s), usually by means of laparoscopy.[1] The procedure is similar to IVF-ET in that ovulation-inducing medications, frequent blood hormone testing, and ultrasonography are necessary for patient monitoring. With GIFT, however, the husband's sperm and wife's eggs are placed into the fimbriated (distal) end of the tube so that fertilization takes place in the more natural environment of the oviduct as opposed to the laboratory dish, as in the case of IVF-ET. Candidates for the GIFT procedure include couples who have completed an infertility investigation in whom traditional therapy has failed to produce a pregnancy. At least one normal patent fallopian tube must be present and the procedure should be performed in a facility meeting the standards of the American Fertility Society.[2]

This paper describes the experience with the GIFT procedure at UMDNJ-Robert Wood Johnson Medical School since April 1990, with emphasis on the role of a GnRH agonist (Lupron®, Tap Pharmaceuticals, Chicago, Illinois) in the ovulation-induction process. It has been suggested that concomitant use of GnRH agonists (GnRH-a) and exogenous gonadotropins during ovulation induction has many advantages including lower cycle cancellation rates (chance of cycle termination prior to the gamete transfer procedure) and higher pregnancy rates.[3]

MATERIAL AND METHODS

All candidates for GIFT had a workup prior to cycling including: evaluation of ovulatory status, hysterosalpingogram, postcoital test, semen analysis, and laparoscopy. All patients had at least two years of infertility, at least one patent fallopian tube, and prior treatment with intrauterine insemination in superovulated (Pergonal,® Serono Laboratories, Randolf, Massachusetts) cycles (four to seven cycles). Patients with

Table 1. *Diagnoses of 94 cycles in 81 patients in the GIFT program.**

	Number	Percent
Endometriosis	44	47
Male factor	32	34
Ovulation dysfunction	30	32
Tubal factor	20	21
Cervical factor	16	17
Unexplained infertility	13	14

*Percentages do not total 100 because many patients had multiple infertility etiologies.

severe male factor infertility (severely reduced sperm density, motility, or percentage normal forms) and severe pelvic adhesive disease were excluded.

GIFT requires the use of follicle-stimulating agents to obtain several mature eggs for transfer. It is the laparoscopic tubal transfer of multiple ooyctes (approximately four) that appears to result in the higher pregnancy rates and higher multiple gestation rates seen with GIFT. Generally, some combination of human menopausal gonadotropins (hMG) [Pergonal®], pure follicle-stimulating hormone (FSH) [Metrodin,® Serono Labs, Randolf, Massachusetts], and clomiphene citrate is utilized. Our center utilized three basic ovulation-inducing protocols: GnRH-agonist (Lupron®) in combination with gonadotropins (hMG and/or FSH); gonadotropins (hMG and/or FSH) alone; and clomiphene citrate in combination with gonadotropins (hMG or FSH).

The GnRH-a protocol involved the daily administration of Lupron® (1.0 mg sc) beginning in the midluteal phase of the cycle preceding the GIFT procedure and continued at a lower dose (0.5 mg sc) during stimulation with hMG and/or FSH until human chorionic gonadotropin (hCG) administration. The hMG and/or FSH protocol involved the use of 150 to 300 IU of Pergonal® and/or Metrodin® daily beginning on cycle day two to three and continuing until the time of hCG. The clomiphene protocol utilized a combination of clomiphene citrate and gonadotropins in either a concomitant or sequential fashion followed by hCG at the time of follicle maturity.

Cycle monitoring was performed in all patients utilizing daily serum estradiol radioimmunoassay measurements and vaginal ultrasonography. hCG was given to trigger oocyte maturation when at least three follicles, with a mean diameter of 16 mm, were noted on ultrasound. GIFT procedures were scheduled 34 to 36 hours following hCG and were performed by laparoscopy at Robert Wood Johnson University Hospital under general anesthesia using standard techniques. Ovarian follicles were punctured with a hollow needle under direct vision and follicular fluid collected. Oocyte retrieval was followed by examination and grading of the oocytes and transfer of the ova and washed sperm suspensions into the tubal ampulla by means of a laparoscopically guided GIFT catheter. Normospermic males had approximately 100,000 motile sperm transferred. Male factor infertility patients had between 200,000 and 500,000 sperm used for gamete transfer in an attempt to compensate for decreased sperm function. A clinical pregnancy was defined as a rising level of beta-hCG followed by the appearance of a gestational sac on ultrasound or evidence of products of conception if spontaneous abortion or ectopic gestation occurred. A biochemical pregnancy was defined as an initial rise in serum beta-hCG with subsequent decline and pregnancy loss before identification of a gestational sac upon ultrasound.

Statistical evaluation involved use of Fisher's exact test with significance defined as $P < 0.05$.

RESULTS

A total of 94 GIFT cycles were initiated in 81 women from April 1990 until July 1991. Mean patient age was 34.8 years with a mean duration of infertility of 3.1 years. Many of the couples undergoing GIFT had more than one infertility factor; therefore, the diagnoses of our patients are expressed as a percentage of total patients (Table 1). Overall, 32 cycles were cancelled (34 percent) prior to laparoscopy, secondary to poor estradiol response, premature luteinization, or inadequate follicular recruitment. A mean of 7.2 oocytes were retrieved from our patients with a mean of 4.8 oocytes transferred per GIFT procedure. Excess oocytes (beyond those transferred) then underwent IVF and embryo cryopreservation for possible future frozen-thawed embryo transfer in a natural cycle if the couple desired.

Cycle characteristics and outcome expressed as a function of ovulation-induction protocol are summarized in Table 2.

Some GIFT cycles begin but never reach the point of laparoscopic oocyte collection and gamete transfer because of poor follicular response to ovulation-induction medication or premature luteinization and ovulation. These cancelled ("dropped") cycles affect reported GIFT pregnancy rates. The clinical pregnancy rate per initiated cycle (a cycle begun but not necessarily completed) was significantly higher where GnRH-a was used for ovulation induction (Table 2). Those cycles utilizing GnRH-a resulted in the highest clinical pregnancy rate per completed cycle (51.9 percent), the highest clinical pregnancy rate per initiated cycle (41.2 percent), and the lowest cancellation rate (20.5 percent) of the three stimulation regimens. The hMG-only stimulation regimen also produced an excellent clinical pregnancy rate per completed cycle (36.4 percent) but with a much higher (46.3 percent) cancellation rate. The clomiphene-hMG protocol gave the poorest outcome of the three

Table 2. *Comparison of ovulation-stimulation regimens for GIFT.*

	I. GnRH-a/hMG/FSH	II. hMG/FSH	III. CC/hMG/FSH
Cycles initiated	34	41	19
Number dropped cycles (%)	7	19	6
Percentage dropped cycles	20.6(7/34)*	46.3(19/41)	31.6(6/19)
Number total pregnancies (biochemical and clinical)	17	8	1
Number clinical pregnancies	14	8	1
Percent multiple pregnancy rate	28.6(4/14)	50.0(4/8)	100.0(1/1)
Percent spontaneous abortion rate	23.5(4/17)	25.0(2/8)	0
Percent clinical pregnancy rate/initiated cycle	41.2(14/34)**	19.5(8/41)	5.2(1/19)
Percent pregnancy rate/completed cycle	51.9(14/27)	36.4(8/22)	7.7(1/13)

*$P < 0.01$
**$P < 0.01$

stimulation regimens (5.2 percent clinical pregnancy rate per initiated cycle). The multiple pregnancy rate was not significantly different between cycles utilizing GnRH-a (28.6 percent) versus hMG-only cycles (50.0 percent; $P > 0.05$), the majority being twin gestations. No ectopic gestations occurred. The spontaneous abortion rate was not significantly different between ovulation-induction regimens. With the exception of those patients suffering first trimester miscarriage, all pregnancies either are ongoing or have delivered.

DISCUSSION

For patients with prolonged refractory infertility, the availability of the assisted reproductive technologies such as IVF-ET and GIFT has opened new treatment options and improved the chance for pregnancy where little or no hope existed. Despite numerous reports attesting to its efficacy,[1,4] GIFT remains a relatively underutilized approach to infertility in women with normal fallopian tubes. National statistics demonstrate that GIFT provides a higher overall pregnancy rate than IVF-ET,[5] though not all IVF-ET patients are appropriate candidates for GIFT. In our experience, using GnRH-a (Lupron®) for ovulation induction results in a greater than 50 percent clinical pregnancy rate/completed cycle, making GIFT the most effective infertility therapy. Unfortunately, GIFT candidates in New Jersey are handicapped by limited or nonexistent insurance coverage for this procedure that can cost between $5,000 and $7,000. It could be argued that early and appropriate utilization of GIFT in competent hands would reduce the need for prolonged, less effective infertility services that currently are covered by third-party carriers in the state.

The use of GnRH-a in conjuction with gonadotropins has been proposed to have many advantages in GIFT and IVF-ET cycles,[6] including more synchronous follicular development, a greater number of retrievable eggs, prevention of premature luteinization, and improved fertilization and pregnancy rates. The ability of GnRH-a to downregulate the pituitary gonadotrope results in a reduction in endogenous gonadotropin secretion. This leads to a state of ovarian suppression (a "medical oophorectomy") resulting from reduced endogenous pituitary gonadotropin secretion and removes any interference with the woman's response to exogenous gonadotropins (Pergonal® or Metrodin®). The high pregnancy rates in our GIFT program demonstrate the value of GnRH-a for ovulation induction. Patients utilizing GnRH-a were more likely to reach the point of egg retrieval (lower cancellation rate) [$P < 0.05$] and more likely to have a clinical pregnancy ($P < 0.05$) than women undergoing GIFT without GnRH-a.

It has been recommended that, prior to GIFT in women with normal pelvic viscera (patent tubes), several cycles of superovulation with gonadotropins be combined with intrauterine insemination (SO-IUI).[7] This often effective approach also increases the number of gametes within the oviducts, avoids laparoscopy, and costs only a fraction of GIFT and IVF-ET. However, some clinicians believe that GIFT offers no advantages over SO-IUI since both procedures increase the number and density of gametes within the fallopian tubes, thereby increasing the chance of pregnancy. The relative efficiency of SO-IUI versus GIFT never has been studied in a prospective randomized fashion. Because all our patients completed at least four SO-IUI cycles prior to GIFT, it appears that GIFT is highly effective and plays an important role in the therapy of refractory infertility even after failed SO-IUI.

One may speculate that the failure of SO-IUI in some patients may be related to impaired gamete transport, deficient egg capture mechanisms, or failure of follicle rupture despite luteinization (luteinized unruptured follicle syndrome). All of these barriers to conception are bypassed by the GIFT procedure, perhaps explaining its high success rate. Unfortunately, no currently available testing can easily identify problems of oocyte release, oocyte capture, and/or gamete transport. Therefore, GIFT must be considered a nonspecific approach to infertility that overcomes multiple potential barriers to fertility.

SUMMARY

Use of GnRH-a combined with gonadotropin therapy during ovulation induction for GIFT appears to offer several advantages, principally a lower cancellation rate (20.6 percent) and higher (51.9 percent) pregnancy rate. The GIFT procedure offers the highest monthly probability of conception (cycle fecundity) of any infertility procedure available and is a highly effective but underutilized method of treating long-term refractory infertility in women with at least one patent oviduct. ■

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Dr. Corsan is GIFT Program medical director, and Dr. Kemmann is director, Division of Reproductive Endocrinology/Infertility, UMDNJ-RWJMS. The paper was submitted in September 1991 and accepted in November 1991. Address reprint requests to Dr. Corsan, UMDNJ-Robert Wood Johnson Medical School, University Center for Reproductive Endocrinology and Fertility, 303 George Street, Suite 250, New Brunswick, NJ 08901.

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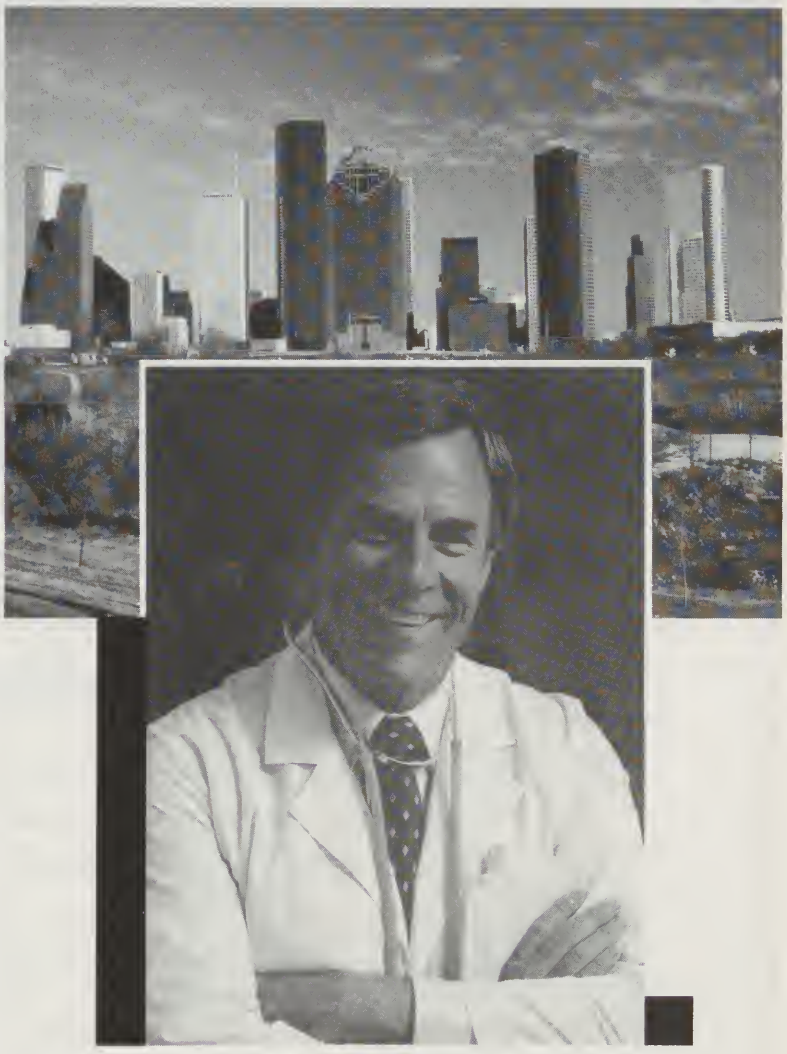
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Robert A. Battista, MD

Small fenestra stapedotomy can improve hearing, improve speech discrimination, and reduce the associated risks of conventional stapedectomy. The authors discuss the advantages and disadvantages of small fenestra, as well as the results of their own stapedotomies.

Otosclerosis, a disease causing fixation of the stapes footplate, is a form of conductive hearing loss that can be corrected by surgery. Stapes surgery was first reported by Kessel in 1876.[1] It was not until 1958 that Shea introduced stapedectomy by total stapes removal and use of a polyethylene-tube prosthesis and vein graft.[2] Although conventional stapedectomy produces good results, the small fenestra stapedectomy (or stapedotomy), with Teflon™ piston insertion directly into a hole made in the stapes footplate, offers the opportunity to improve hearing while reducing associated risks of conventional stapedectomy.[3-5]

The purpose of this report is to review our results of stapedotomy and to discuss the advantages and disadvantages of the stapedotomy technique.

MATERIALS AND METHODS

The authors reviewed the records of 41 patients (a total of 45 operations) who underwent stapedotomy for otosclerosis from September 1985 through January 1991. Patient ages ranged from 18 to 71 years with a median age of 41 years. There were 25 females and 16 males. Preoperative audiograms were performed within one month of the operation and postoperative audiograms were performed one month to two years postoperatively.

All patients were operated on under local anesthesia. First, the tympanomeatal flap was elevated, exposing the posterior half of the middle ear space. External canal bone then was removed with a curette or a diamond bur to expose the entire stapes. Using a calibrated measuring rod, the distance from the stapes footplate to the undersurface of the incus was measured to determine the proper length for the piston prosthesis. A control hole then was made with a pick in the stapes footplate. This precautionary step was done to facilitate footplate removal if pressure exerted during removal of the stapes crura resulted in a mobile or "floating" footplate. Next, the incudostapedial joint was disarticulated, the stapes tendon was cut, and the stapes crura was cut close to the footplate.

Using a 0.6 mm manual diamond bur, a fenestra was created in the middle portion of the footplate. A 0.4 mm Teflon™-platinum wire piston prosthesis was cut to length and then attached to the incus and lowered into the fenestra. Blood from the incision was used to seal the prosthesis in the fenestra. The tympanomeatal flap was returned to its anatomic position and the ear canal was filled with antibiotic ointment. Total operative time for the procedure was less than one hour.

RESULTS

The amount of hearing improvement is reported by calculating the postoperative air-bone gap, the difference between the audiometric preoperative bone-conduction thresholds and the postoperative air conduction thresholds. By convention, the postoperative air-bone gap is calculated by subtracting the preoperative 3-frequency bone-conduction average over 0.5 kHz, 1 kHz, and 2 kHz from the postoperative air-conduction average at these frequencies. In 69 percent of our patients, the air-bone gap was 10 dB or better; in 85 percent, the air-bone gap was 15 dB or better; and all but one patient had an air-bone gap better than 30 dB (Table 1).

Speech discrimination scores also were evaluated (Table 2). Speech discrimination is considered the most sensitive measure of sensorineural function since it measures the ability to discriminate language. Forty patients (89 percent) either had no change in speech discrimination or showed a 7 percent or greater

Table 1. *Postoperative air-bone gap.*

Air-Bone Gap	Number of Patients	Percent
0-5 dB	19	42
6-10 dB	12	27
11-15 dB	7	16
16-30 dB	6	13
> 30 dB	1	2

Table 2. *Postoperative speech discrimination score results.*

	Patients	Percent
No change, or within 7% or better	40	89
7% or worse	5	11

increase in postoperative discrimination scores. Five (11 percent) patients had a 7 percent or greater decrease in postoperative discrimination scores.

Complications have been minimal with the stapedotomy technique. Only one patient developed a profound sensorineural hearing loss, and this was caused by a reparative granuloma.

Recurrent conductive hearing loss occurred in two patients. This was caused by a loose wire attachment to the incus in one patient and head trauma in another patient.

Postoperative vestibular problems are reduced in stapedotomy because there is less manipulation of the footplate and, thus, minimal labyrinthine trauma, compared to conventional stapedectomy. Only 6 percent of our stapedotomy group complained of postoperative dizziness. There were no cases of postoperative perilymph fistulas.

DISCUSSION

In any surgical technique, minimal iatrogenic trauma is a primary goal. Minimal disturbance is critical to obtain maximal hearing gain and minimal postoperative morbidity stapedotomy. For this reason, many surgeons have expressed a preference for stapedotomy as the operative procedure of choice for patients with otosclerosis.[1,6,7] Compared to conventional stapedectomy, stapedotomy has been proposed as less traumatic to the inner ear,[4,8] easier to perform,[7] preventing migration of the prosthesis,[1] and allowing for better long-term hearing results,[5] and better hearing results at 4,000 Hz.[9]

The importance of normal hearing sensitivity in the higher frequencies from 2,000 Hz to 6,000 Hz has been demonstrated by speech scientists.[10] This is because several phonetic sounds, such as "th," "ch," and "s" contain primarily high frequency sounds. In addition, normal high frequency hearing is required for adequate speech discrimination in the presence of competing noise.[10] This may explain the high percentage (89 percent) of our patients with improved speech discrimination scores, since stapedotomy can improve hearing over all frequencies especially at 4,000 Hz.

There are some technical difficulties that are inherent to stapedotomy. These include fracturing the crura without disturbing the footplate; creating a fenestra 0.6 mm in diameter in the proper position on the footplate; and simultaneously placing the prosthesis into the fenestra and onto the incus. Farrior suggests stapedotomy is contraindicated in patients such as divers, pilots, and patients with patulous eustachian tubes who are subjected to excessive middle ear pressure changes.[11]

CONCLUSION

Small fenestra stapedectomy (or stapedotomy) as a surgical treatment for otosclerosis entails the least surgical trauma. Labyrinthine trauma is minimized with the stapedotomy technique, thus reducing the risk of vestibular disturbance and severe or profound sensorineural hearing loss. At the same time, stapedotomy achieves good hearing results and improves speech discrimination. ■

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Dr. Jahn is professor and chief, Section of Otolaryngology Head and Neck Surgery, UMDNJ-New Jersey Medical School. Dr. Battista is clinical fellow in neurotology, Warren Otologic Group, Warren, Ohio.

The paper was submitted in September 1991 and accepted in November 1991.

Address reprints requests to Dr. Jahn, UMDNJ-New Jersey Medical School, H-586, 185 South Orange Avenue, Newark, NJ 07103.

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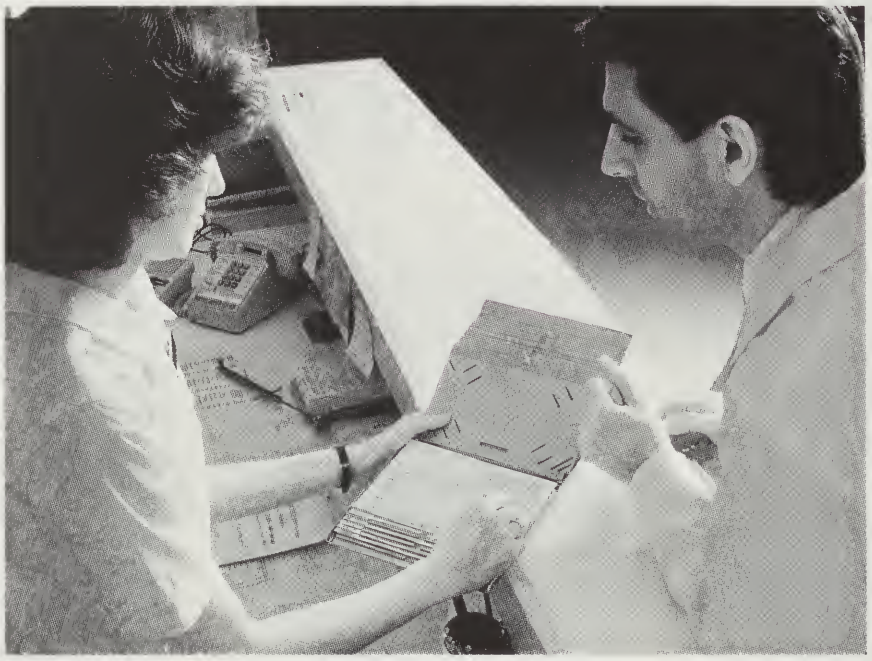
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Eosinophilia-Myalgia Syndrome Not Associated with L-Tryptophan

Michael A. Patmas, MD

The author reports a case of eosinophilia-myalgia syndrome (EMS), not associated with the use of tryptophan. Other nutritional supplements should be considered as possible etiologic agents in EMS. Further research in this area is needed.

Since the initial description of eosinophilia-myalgia syndrome (EMS), reports have been published showing an association with tryptophan ingestion and EMS.[1] A chemical contaminant referred to as "peak-E" and identified as 1,1′-ethylidenebis [tryptophan] has been demonstrated in retail lots of tryptophan consumed by patients with EMS and implicated as the possible causal agent or a marker for an unidentified causal agent.[2] Recently, a patient with biopsy-proved EMS, meeting the Centers for Disease Control (CDC) diagnostic criteria who did not consume tryptophan, but who was consuming lysine in addition to a variety of other vitamins, minerals, supplements, and homeopathic remedies, has been identified.

In 1989, a 33-year-old white female complained of fatigue and dizziness. She was referred to a physician specializing in alternative medicine who diagnosed Lyme disease, chronic candidiasis, and chronic mononucleosis. She was started on an array of supplements and homeopathic remedies including lysine in February 1990. Initial physical examination and laboratory studies, including eosinophil count, were normal. Over the next several months, the patient began to develop myalgias, edema, thickening and induration of the skin, particularly of the distal extremities, and marked blood eosinophilia with counts greater than 1.8 x $10^3/mm^3$. The vitamin therapy was continued and she began to develop marked hardening of the skin associated with disabling flexion contractures of the elbow, fingers, and ankles. One year after initiation of this therapy, the author evaluated the patient. Full thickness skin, muscle, fascia, subcutaneous tissue, and lymph node biopsies were obtained and revealed changes typical of EMS with muscle atrophy, as well as eosinophilic and lymphocytic infiltration (Figure). The patient was advised to discontinue immediately the vitaman therapy and within one week her skin began to soften. The patient was referred to a major university medical center with experience in the diagnosis and treatment of EMS; the diagnosis was confirmed. High-dose prednisone therapy was initiated with a good response.

This case is of particular interest because it was not as-

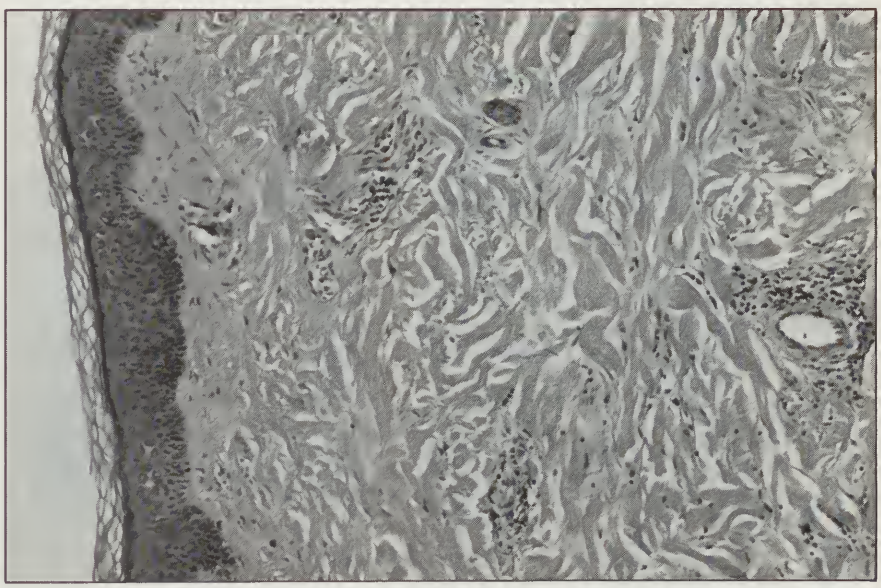


Figure. Biopsy of skin and subcutaneous tissue demonstrating changes typical of EMS. Photograph prepared by Ramesh Mahapatro, MD, Pathology Department, Community Medical Center, Toms River.

sociated with the use of tryptophan. Approximately 3 percent of patients with EMS have not utilized tryptophan and the causative agent remains a mystery though lysine has been suspected in three other cases. This case suggests that EMS can be associated with supplements other than tryptophan. Clearly, further research in this area is needed in addition to greater regulation of alternative medicine and appropriate vitamin and mineral supplementation. ■

Reviewer's comment. Doctor Patmas's case report emphasizes the pressing need for the establishment of a more rigorous set of regulations in the dispensing of nutritional supplements. The tocsin is sounded especially for the geriatric population, 23 million of whom are enthusiastically consuming nutritional supplements.

Mr. William Barnhill, an investigative reporter, stated that an appraisal by the Federal Drug Administration (FDA) placed current sales at more than $6 billion yearly, a 12-fold increase since 1972 (*AARP Bulletin* 32:12, 1991). He further added that a survey completed by the FDA revealed 66 to 72 percent of persons 65 or over were using supplements in potentially toxic doses. The article decried the compounding of the problem by physicians with inadequate backgrounds in nutrition.

Currently, a task force of the FDA is addressing the problem with proposals for tough new labeling requirements including warnings. A perusal of Mr. Barnhill's article is recommended. □ P.A. Ruggieri, MD

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Dr. Patmas is affiliated with Community Medical Center, Toms River.

The paper was submitted in November 1991 and accepted in January 1992.

Address reprint requests to Dr. Patmas, 1749 Hooper Avenue, Toms River, NJ 08753.

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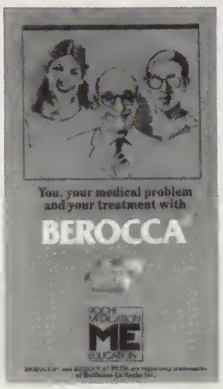
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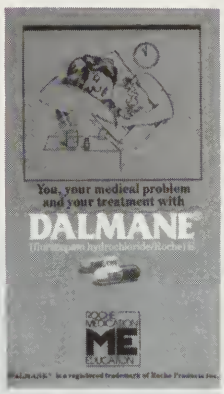
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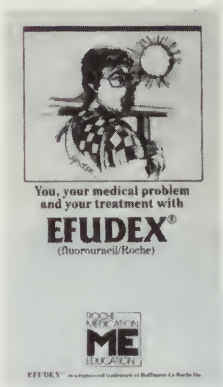
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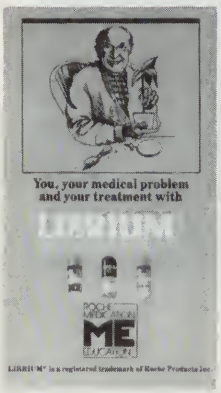


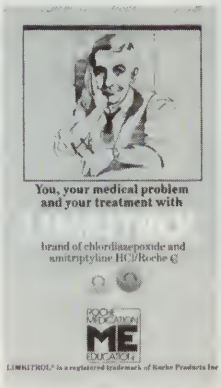
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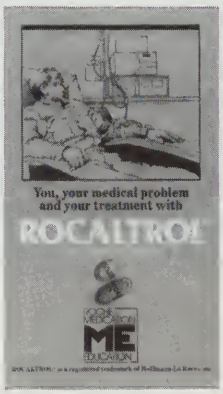
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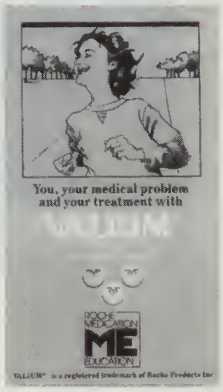
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Results of Surgery and Radiotherapy for Early Breast Cancer

Sun H. Liauw, MD
Louis J. Sanfilippo, MD
K. David Steidley, PhD
Howard Morris, MD

Primary radiotherapy for 127 early breast cancers produced five-year local control of 96.1 percent and NED results of 81.1 percent. Results from a large community cancer center in New Jersey are comparable to results of major university cancer centers.

Breast conservation surgery and primary radiotherapy is a well-established treatment for early cancer of the breast. Extensive prospective and retrospective studies from large cancer institutions and university centers reveal that results are equal to those with total mastectomy or modified radical mastectomy.[1-12] The National Institutes of Health (NIH) Consensus Development Conference in June 1990 concluded, "Breast conservation treatment is an appropriate method of primary therapy for the majority of women with stage I and stage II breast cancer and is preferred because it provides survival rates equal to those of total mastectomy plus axillary dissection while preserving the breast."[13]

The purpose of this report is to review 127 cases of stage I and stage II breast cancer treated from 1981 to 1984 with excision of the primary tumor and adjacent breast tissue followed by external beam radiotherapy and to analyze survival, local control, cosmesis, and complication rates. It would be of interest to show whether patients treated in a large community cancer center in New Jersey can achieve similar results to those of major cancer centers.

MATERIALS AND METHODS

A total of 129 women with clinical stage I or stage II invasive breast cancer were treated with conservative surgery and external beam radiotherapy at Saint Barnabas Medical Center from January 1981 to December 1984; 2 patients were lost to followup. A total of 127 patients were available for review. Followup ranged from 60 to 116 months with a median of 78 months. Ages ranged from 30 to 84 years with a mean age of 57 years. According to the American Joint Committee on Cancer staging system, 75 patients had stage I cancer, and 52 patients had stage II cancer (Table 1). Pathology of the tumors was infiltrating ductal in 91 percent (116 of 127 patients) of the cases while other types accounted for 9 percent [mucinous (1), tubular (3), lobular (3), small cell (1), medullary (2), and unspecified type (1)].

SURGICAL PROCEDURES

One hundred twenty-four patients underwent excision of the primary tumor with 76 percent (97 of 124 patients) receiving a wide excision, e.g. segmental mastectomy, wedge resection, or

Table 1. *Primary radiotherapy of breast cancer clinical staging.*

Stage	Number of Patients	Percent
I	75*	59
II	52	41
Total	127	100

*Mammographic findings only: 12/127 (9.3%).

Table 2. *Primary radiotherapy of breast cancer; locoregional recurrence versus clinical stage.*

Stage	Breast	Regional Lymph Nodes
Stage I	2/75 (2.7%)	0/75 (0%)
Stage II	3/52 (5.8%)	1*/52 .(1.9%)
Total	5/127 (3.9%)	1/127 (0.8%)

*Patient has local recurrence and regional recurrence.

Table 3. *Primary radiotherapy of breast cancer; summary of five cases with locoregional recurrence.*

	Stage I	Stage II
Number of Patients	2	3
Salvaged Mastectomy	2	2
Survival NED	1	1
Dead of Intercurrent Disease	1	0
Dead of Cancer	0	2

Table 4. *Primary radiotherapy of breast cancer.*

(Kaplan-Meier Survival Analysis)

Stage	Survival	Five-Year Rate (%)	Seven-Year Rate (%)
I	Overall	88.0	85.3
	NED	85.3	81.2
	Disease Specific	93.1	91.6
II	Overall	78.9	67.8
	NED	75.0	68.6
	Disease Specific	85.7	75.9
I and II	Overall	84.3	78.6
	NED	81.1	76.1
	Disease Specific	90.1	85.7

Failure points are as follows:

Overall Survival: Patients are alive (with or without breast cancer) at the time of last followup. Failure point is death due to any cause.

NED Survival: Patients are alive and without evidence of breast cancer at the time of last followup. Failure points are death due to any cause or recurrences that were not salvagable.

Disease-Specific Survival: Patients are alive (with or without breast cancer) at the time of last followup. Failure point is death due to breast cancer only.

Table 5. *Primary radiotherapy of breast cancer.*

Cosmetic Results in 101 Assessed Stage I and Stage II Breast Cancer Patients

Cosmesis*	Number of Patients	Percent
Excellent	31	31
Good	54	53
Fair	11	11
Poor	5	5
Total	101	100

*Criteria—Contour deformity, skin and subcutaneous changes, breast retraction, and fibrosis.

partial mastectomy; the other patients underwent simple excision. The three exceptions were incisional biopsy (1), aspiration needle biopsy (1), and no breast biopsy staged as T_0N_1 (1). A total of 36 of 124 patients (28 percent) underwent re-excision because of either positive margins, tumor close to margins, or uncertain margins. Axillary lymph node dissection was performed in 106 patients. The number of lymph nodes removed ranged from 1 to 41 nodes with an average of 15 nodes. In 66 stage I patients with lymph node dissection, histologically positive nodes were found in 15 of 66 patients (23 percent); in stage II, 21 of 40 patients (52 percent).

RADIOTHERAPY

A total dose of 45 to 50 Gy in five weeks was given to the whole breast via medial and lateral opposed tangential ports using Co-60 irradiation. An additional boost dose of 10 to 16 Gy with electrons in one to one and one-half weeks was given to the breast scar (6 MV) or primary site (6, 9, or 12 MV). Regional lymphatics routinely were irradiated until mid-1982 when a policy of local excision plus axillary dissection followed by breast-only irradiation for those with early T stage tumor and limited or absence of axillary spread gradually was implemented. Computer tomography (CT) simulation was employed in the treatment planning of all patients. The details of treatment have been described.[14]

CHEMOTHERAPY

A total of 39 patients received chemotherapy, usually cyclophosphamide, 5-fluorouracil, and methotrexate. Of these patients, 31 patients had positive axillary lymph nodes and 8 patients had other high-risk factors. Twenty-eight of 39 patients received CF chemotherapy with concurrent radiotherapy and later received methotrexate.

RESULTS

With a median followup of six and one-half years and a minimum followup of five years, a local control of 96.1 percent (122 of 127 patients) and a regional control rate of 99.2 percent (126 of 127 patients) was achieved (Table 2). In stage I cancer patients, the local recurrence rate was 2.7 percent (2 of 75 patients); in stage II cancer patients, it was 5.8 percent (3 of 52 patients). The

lone regional recurrence was in a stage II cancer patient in whom a local recurrence also had occurred. Four of 5 recurrent cases underwent salvage mastectomy. Two patients survived no evidence of disease (NED), 1 patient died of intercurrent disease, and the other 2 patients (both stage II cancer patients) died of distant metastases (Table 3).

Using the Kaplan-Meier method,[15] the five-year NED survival rate for stage I cancer patients was 85.3 percent; for stage II, the survival rate was 75.0 percent; and for stages I and II, the survival rate was 81.1 percent. A complete statistical analysis is detailed in Table 4 and shown graphically in Figures 1, 2, and 3.

Serial photographs and recorded clinical observation for cosmesis were available in 101 patients. The criteria of excellent, good, fair, or poor cosmesis were based on the contour deformity, breast retraction, fibrosis, and skin or subcutaneous changes. Details of these criteria have been stated in our previous series.[14] Good to excellent breast cosmesis was achieved in 85 of 101 patients (84 percent) assessed. Specifically, 31 percent of patients were rated as excellent, 53 percent of patients were rated as good, 11 percent of patients were rated as fair, and 5 percent of patients were rated as poor (Table 5). Examples for excellent and good cosmesis are shown in Figures 4 and 5, respectively.

Side effects and complications were minor. Breast cellulitis and symptomatic pneumonitis occurred in three patients. Two patients developed symptomatic pericarditis that spontaneously resolved. Arm edema measuring greater than or equal to 2 cm to 3.5 cm occurred in seven patients (Table 6).

DISCUSSION

Our local control rates of 97.3 percent for stage I cancer patients and 94.2 percent for stage II cancer patients (Table 2) are compatible with results from prospec-

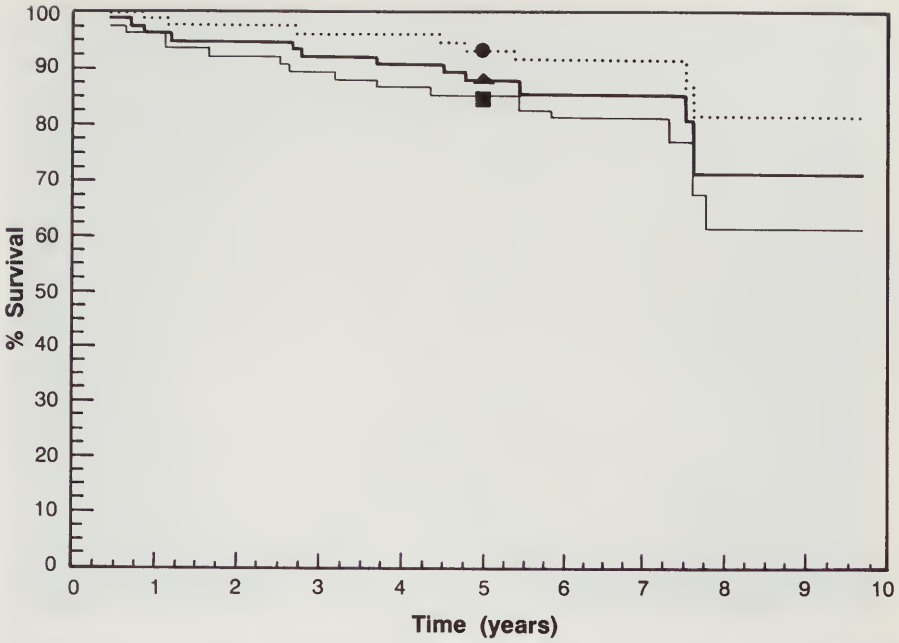


Figure 1. Survival curves for stage I breast cancer after conservative surgery and radiotherapy. At five years, the disease specific (●), overall (▲), and NED (■) survival rates were 93.1 percent, 88.0 percent, and 85.3 percent, respectively.

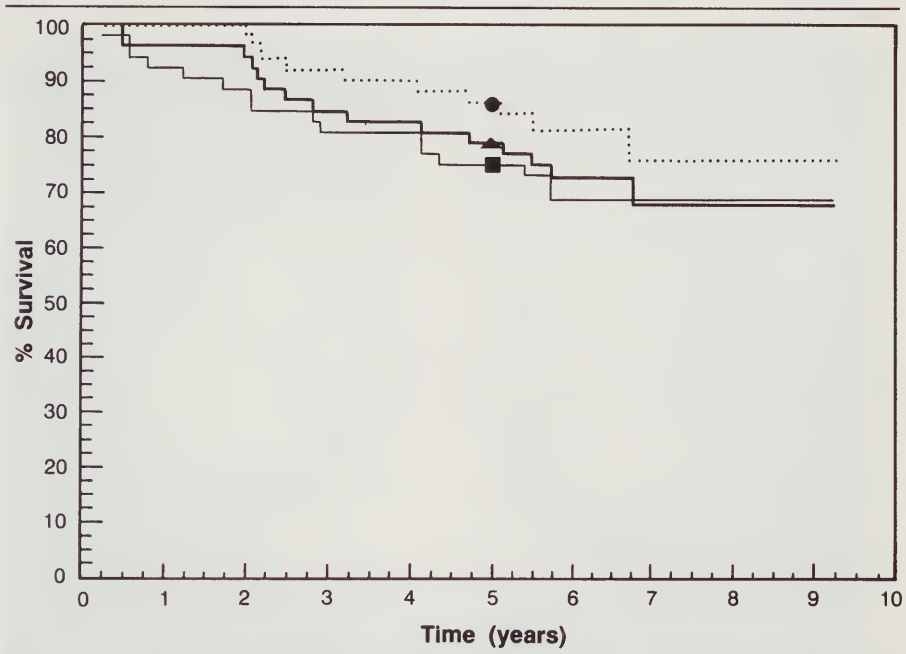


Figure 2. Survival curves for stage II breast cancer after conservative surgery and radiotherapy. At five years, the disease specific (●), overall (▲), and NED (■) survival rates were 85.7 percent, 78.9 percent, and 75.0 percent, respectively.

Table 6. *Primary radiotherapy of breast cancer.*

Complications in 127 Cases	Number of Patients	Percent
Breast Cellulitis	3	2.4
Symptomatic Pneumonitis	3	2.4
Symptomatic Pericarditis	2	1.6
Arm Edema*	7	5.5
Rib Fracture	0	0

*2 to 3.5 cm midhumeral circumference difference.

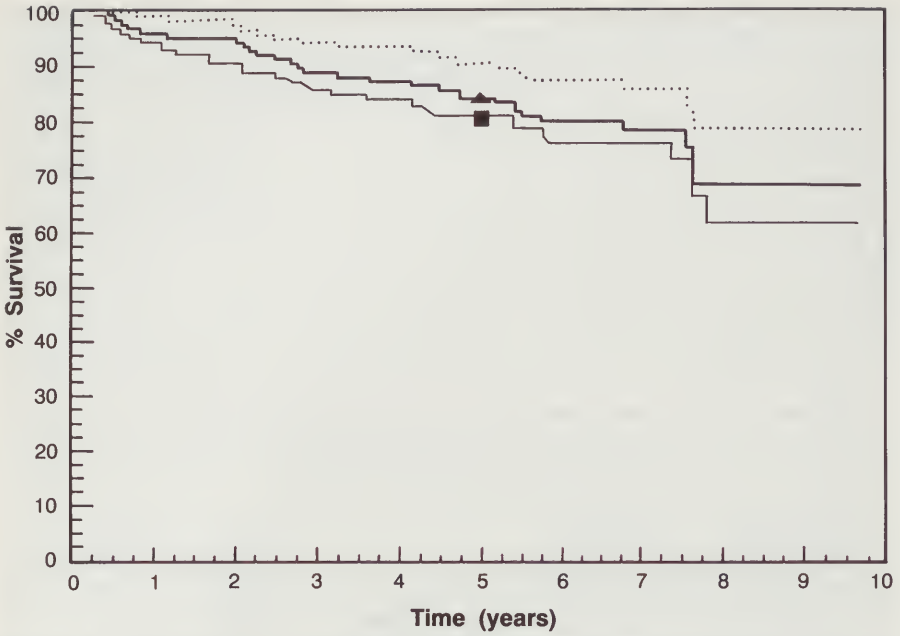


Figure 3. Survival curves for stages I and II breast cancer after conservative surgery and radiotherapy. At five years, the disease specific (●), overall (▲), and NED (■) survival rates were 90.1 percent, 84.3 percent, and 81.1 percent, respectively.

tive studies of 95 to 98 percent for stage I cancer patients[1,2] and 93 percent for stage I and stage II cancer patients[3] as well as results from retrospective studies of 91 to 95 percent for stage I and stage II cancer patients[5,6,8-12] at five years (Tables 7 and 8).

Our five-year NED survival rates of 85.3 percent for stage I cancer patients and 75.0 percent for stage II cancer patients also are compatible with prospective studies of NED survival rates of 85 percent[1,2] for stage I cancer patients and 66 to 70 percent for stage I and stage II cancer patients,[3,4] as well as results of 83 to 90 percent for stage I and stage II cancer patients from retrospective studies (Tables 7 and 8[5-7,9]).

Cosmetic results from our study with 84 percent good to excellent cosmesis also are compared favorably with 77 to 90 percent good to excellent cosmesis reported from other centers.[7,8,12,16-18,20]

As concluded by the NIH Consensus Conference in 1990, treatment of early breast cancer with conservation surgery and irradiation provides a local tumor control and survival rate equal to those of total mastectomy. It is preferable for the majority of women with stage I and stage II breast cancer because it preserves the breast with a good cosmesis and maintains body image.

With a longer followup, the rate of local recurrence increases after treatment by irradiation or mastectomy. As pointed out by Fowble in a report of 697 clinical stage I and stage II breast cancer patients treated for over a decade by excision, axillary dissection, and definitive irradiation, the cumulative probability of isolated breast recurrence of 6 percent at five years rose to 16 percent at ten years. Similar ten-year actuarial recurrence rates also were found in other series ranging from 8 to 20 percent for conservation surgery and irradiation and a 10 to 23 percent recurrence rate for modified mastectomy with the modal and median rate being 15 to 18 percent for either approach.[12]

However, relapse in the breast after conservation surgery and irradiation is not a grave prognostic sign. It appeared well established that the prognosis of an operable breast recurrence is considerably more favorable than that of chest wall recurrence after mastectomy where 4 to 13 percent 5-year survival rate was reported by Haagensen and Donegan.[19] A salvage mastectomy can be performed in 76 to 97 percent of the patients.[8,11,17,20-26] It is an effective second surgery with a survival rate of 59 to 73 percent at 5 years[20,21,25,26] and 49 to 57 percent survival rate at 10 years.[25,26] In Veronisi's series,[27] 88 of 102 patients with local failure of stage I treated 7 to 20 years before are alive. Late recurrence (after 3 years) yielded a higher 5-year survival rate of 87 percent versus 44 percent for recurrence diagnosed before 3 years after conservation surgery and irradiation.[21]

Lumpectomy and irradiation are not always applicable for all women with stage I and stage II breast cancer. As has been pointed out by the NIH Consensus Conference, women with multicentric disease, with diffuse microcalcification seen on mammogram, those with a tumor relatively large in proportion to the breast size, and women with certain collagen vascular disease—in whom conservation treatment would produce an unacceptable cosmetic result—are not candidates for conservation surgery and irradiation.

CONCLUSION

Breast conservation surgery and radiotherapy can be satisfactorily performed in a community cancer center setting. This report also confirms the conclusion of the NIH Consensus Statement that survival rates of treatment for early breast cancer with conservation surgery and irradiation are equal to those of total mastectomy. Patients now have choices of treatment. Hopefully, "breast conservation surgery and radiation as a preferable method of treatment for the majority of women with early breast cancer," as stated by the NIH Consensus Conference, can be conveyed effectively by physicians to their patients.

Since the breast can be preserved to the patient's psychological advantage, more

women will understandably choose the breast conservation option. This option, therefore, needs to be stressed as part of the informed consent procedure. ■

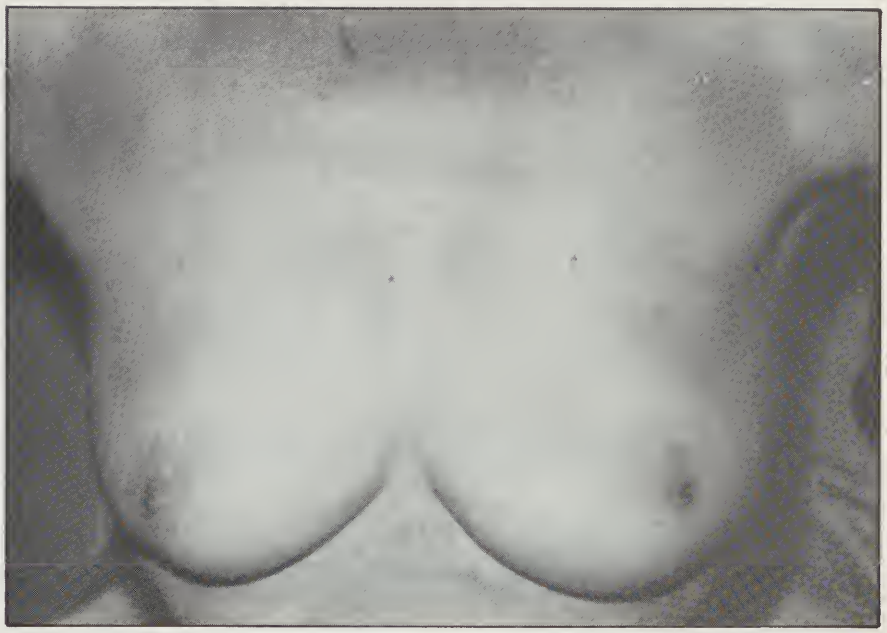


Figure 4. T_1N_0 cancer of left breast with an upper central lesion. This is an example of excellent cosmesis. The patient is post-treatment with no evidence of recurrence with 7.5 years followup.

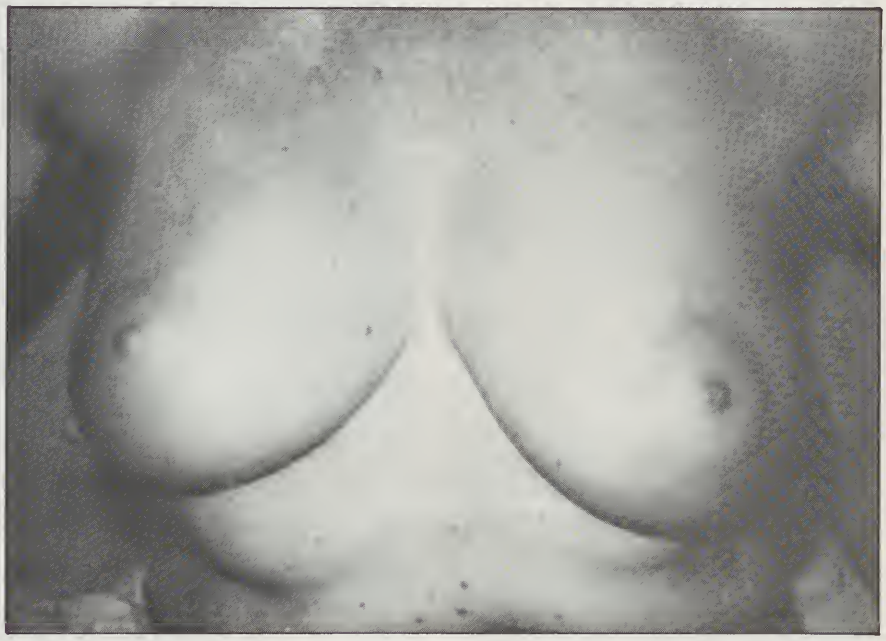


Figure 5. T_1N_1 cancer of right breast with upper outer quadrant lesion. This is an example of good cosmesis. The patient has mild breast shrinkage post-treatment with no evidence of recurrence with six years followup.

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Table 7. *Prospective studies—conservation surgery (CS) and irradiation (RT) versus mastectomy (M).*

			CS & RT			M		
Trial	Total No. of Pts.	Stage	Years of Followup	Local Tumor Control %	NED Survival %	Type	Tumor Control %	NED Survival %
Roussy[1]	179	I	5	—	85	MRM	—	74
			10	95	65		90	58
Milan[2]	701	I	5	—	85	HM	—	82.5
			10	98	77		98	76
NSABP[3]	1214	I, II	5	93	70	TM	—	65
			8	90	59		92	54
NCI[4]	247	I, II	8	80	66	MRM	88	76

MRM: Modified radical mastectomy
HM: Halsted mastectomy
TM: Total mastectomy

Table 8. *Retrospective studies—conservation surgery and radiotherapy stage I and stage II breast cancer.*

Institution	Total No. of Cases	Five-Year Local Control (%)	Five-Year NED Survival (%)
Curie[5]	324	92	90
M.D. Anderson[6]	118	95	83
Marseilles[7]	780	—	85
Basel[8]	410	91	—
Roussy[9]	436	95	84
JCRT[10]	148	94	—
Yale[11]	278	91	—
University of Pennsylvania[12]	697	92	—
Saint Barnabas Medical Center	127	96	81

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Drs. Liauw, Sanfilippo, and Steidley are affiliated with the Department of Radiation Oncology, Saint Barnabas Medical Center. Dr. Morris is affiliated with the Department of Radiation Oncology, St. Michael Hospital, Texarkana, Texas.

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Address reprint requests to Dr. Liauw, Saint Barnabas Medical Center, Old Short Hills Road, Livingston, NJ 07039.

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New Jersey's 15-Year Experiment in Altered Physician-Patient Relations

Michael A. Nevins, MD

New Jersey has served as a "social laboratory" by initiating innovations affecting physician-patient relations. Some of these changes include use of ethics committees, influence of the Bioethics Commission, and government review of nursing home decision making.

In 1976, New Jersey's Supreme Court ruled in the case of Karen Ann Quinlan that life-sustaining medical treatment could be terminated although by so doing the patient's life would be jeopardized.[1] In 1990, when the United States Supreme Court considered the same issues in the case of Missouri's Nancy Beth Cruzan, Justice Sandra Day O'Connor suggested that, rather than crafting a uniform national legal standard, future developments should be left to "the laboratory of the states."[2] If we adopt this metaphor, New Jersey has served as such a social laboratory and events of the 15 years after the Quinlan case can be thought of as a complex, medical-legal "experiment." The following analysis will consider some of these laboratory results particularly as they apply to the physician-patient relationship and to the process of medical decision making.

For more than two millenia, the doctor's proper role, as articulated in the Hippocratic oath, was to use his judgment to benefit the patient. Just 100 years ago, Oliver Wendell Holmes advised medical students that "your patient has no more right to all the truth you know than he has to all the medicine in your saddlebags . . . he should get only just so much as is good for him."[3] A physician's motives might have been altruistic and fiduciary, but his relationship to the patient was unilateral and authoritarian. In recent years, however, such physician behavior often has been characterized pejoratively as being paternalistic.

In the Quinlan case, New Jersey's Supreme Court profoundly altered this physician-patient dynamic. Acknowledging that there are times when the individual's right to refuse medical treatment overcomes state interests, the Court listed among the latter "the right of the physician to administer medical treatment according to his best judgment." As a result, the Quinlan decision reduced the ability of physicians to rely upon their own independent professional intuitions. At the same time, it introduced to the bedside, a group of nonphysicians who would play increasingly important roles or, as one commentator observed, the Quinlan case provided "the bridge for lawyers and judges to cross over into medicine."[4]

Later, New Jersey Supreme Court decisions further refined the new ground rules about how end-of-life decisions should be made. The Claire Conroy case of 1985 involved a terminally ill woman with irreversible physical and mental impairment and was the first time that a high court addressed the issue of withdrawing artificial fluids and nutrition.[5] Two years later, in a trilogy of decisions (Jobes, Peter, and Farrell), the Supreme Court expanded on its previous rulings.[6-8] Both Nancy Jobes and Hilda Peter were permanently unconscious and were being sustained by artificial feedings. Kathleen Farrell, who suffered from end-stage amyotrophic lateral sclerosis, retained the capacity to decide for herself and had opted to discontinue her respirator. In none of these decisions did the court advise whether or not life support should be withheld or withdrawn, but rather, it defined who may make such decisions and what procedures to follow.

The result of all this new case law was to establish a legal framework based upon the patient's condition on one hand and on the degree of certainty about how the patient would want to be treated on the other (Table).[9-10] The Supreme Court acknowledged that the locus of medical decision making should be at the bedside rather than in courts, but altered the dynamics between physician and patient/family. Indeed, in 1988, in the case of Largey versus Rothman, they

changed the legal standard of what information should be disclosed to a patient from "what a reasonable physician would provide" to what a prudent patient would want to know to make an informed decision.[11]

While the Quinlan decision was a pivotal historic event in which the balance of power shifted from physician to patient, the Cruzan decision gave federal validation to this shift in emphasis from physician's judgment to patient's preference. In fact, the United States Supreme Court in the Cruzan case did not even discuss the issue of physician prerogatives or the sanctity of the physician-patient relationship. (In the Cruzan case, another hallowed institution, the family, also was undermined when the court affirmed that states may override the traditional clinical practice of relying upon families to make decisions about life-sustaining treatment for incompetent patients. In this way, the court sought to protect such patients from the judgments of others, even if those others were close and loving family members.)

The Quinlan decision did not occur in a vacuum. By the mid-1970s, new social, political, and economic realities impacted upon how people felt about individual autonomy and there was increasing, sometimes strident, emphasis on legal rights—civil as well as sexual. Traditional authority figures no longer were deferred to as readily as in the past and so it should not be surprising that there was an emerging sense of distrust of physicians' judgment and even of their motives. Inevitably, many of these social phenomena became reflected in judicial thinking.

Nor was it an accident of history that the first "right-to-die" case was heard in New Jersey since the state's Supreme Court always has been quick to embrace new social challenges. Perhaps this reflects the enduring influence of former Justice William Brennan who was elevated from the state's high court to the United States Supreme Court in 1956 where he became the acknowledged leader of the Court's liberal wing. (Ironically, Brennan's last case was the Cruzan decision.) However, the New Jersey judiciary's progressivism was balanced by the state Legislature's reticence and conservatism so that, paradoxically, although our Supreme Court is considered to be the pioneer in developing case law concerning "right-to-die" issues, this state lagged behind almost all others in formulating overarching statutory law. While the nation's first "living will" statute was passed in California in 1976, only a few months after the Quinlan case, New Jersey did not pass its own version until June 20, 1991.

JUDICIAL INNOVATIONS

Patients like Karen Quinlan, Nancy Jobes, Hilda Peter, and Nancy Cruzan all were in a state referred to as a persistent vegetative state (PVS). Patients with this rare condition may appear to be awake, but they are not aware. They neither are "brain dead" nor terminally ill, but are permanently unconscious; some have been kept biologically alive for years or even decades. Most state courts have held that appropriate surrogates are legally permitted to withhold or withdraw life-sustaining medical treatment from patients in this condition. This can be legally understood as allowing nature to run its course rather than as being an overt act of causing death.

An important distinction between the judiciary's focus in New Jersey as opposed to Missouri's in the Cruzan case is that for the latter, the critical issue in PVS is whether or not there is "clear and convincing" evidence that the patient would not have wanted treatment to be continued while in New Jersey the focus is on prognosis. The Quinlan formula for PVS calls for independent confirmation by two neurologists that there is "no reasonable likelihood of return to a cognitive, sapient state" regardless of whether the patient has ever expressed his feelings.

In its Conroy decision in 1985, New Jersey's Supreme Court ruled that the same burdens versus benefits considerations could be applied for terminating tube feeding as for any form of medical treatment. At the same time, the Court was sensitive to the potential vulnerability of frail, sometimes isolated nursing home patients and proposed a decision-making framework that balanced medical concerns against patient values. The Court found that even lacking trustworthy knowledge of a terminally ill patient's wishes, treatment could be withheld or withdrawn on the basis of what is judged by others to be in the patient's "best interests." However, they narrowly limited such decisions, which necessarily are based on "quality of life," to the single criterion of whether or not the patient is suffering from intractable pain.

A controversial innovation in the Conroy case was the Court's suggestion that withholding medical treatment from nursing home patients might represent "abuse" and, therefore, every instance of nonaggressive treatment would have to be investigated by a state agent, the Ombudsman for the Institutionalized Elderly, who previously had been responsible for seeking out instances of physical or financial abuse. From the beginning, this procedural twist was seen by many as well meaning, but conceptually flawed.

The Ombudsman in New Jersey has unusual independence; successive leaders of the agency had characterized their role as being advocate, arbitrator, or auditor.[12] Many health professionals, however, perceived the Ombudsman and his agents as being bureaucratic micromanagers, threatening watchdogs, or as "big brother at the bedside."[13] In 1988, the situation deteriorated markedly when the

Ombudsman publicly declared that, in his opinion, terminal care in New Jersey's nursing homes often was equivalent to "terminal neglect." The agency distributed guidelines suggesting that a decision to eschew even a urinalysis might warrant investigation. Abuse clearly is in the eye of the beholder and depends upon clinical circumstances.[14] However, the Ombudsman's office favored a narrow, cookbook acceptance of what treatment was medically beneficial as opposed to a more holistic approach of making decisions proportionate to the patient's over-all condition.

The Ombudsman's expanded supervisory role was widely understood to be a radical departure from conventional medical decision-making practice and sometimes affected the natural flow of patients from hospitals to nursing homes; the latter no longer were seen as havens where incurable patients could be sent for comfort-oriented care unless the treatment plan satisfied legal standards according to the strict interpretation of the state agency.

A constructive result of this strange experiment was to focus attention on the difficult question of how to understand whether or not a treatment is futile. People may legitimately disagree over whether certain goals are worth pursuing or how one should distinguish between what is or is not beneficial. For example, although so-called "miracle cases" are widely reported, the likelihood of an adult patient making a meaningful improvement after more than a few weeks in a persistent vegetative state is remote.[15-16] Nonetheless, some would choose to "hope for a miracle" or so value biologic life that they would want to be sustained on life-support machines regardless of their condition. In one survey of the attitudes of 405 outpatients, 85 percent chose against life-sustaining treatments if they would be in a vegetative state.[17] Given such long odds, a particularly controversial issue is whether costly, but what most people would consider hopeless, treatment should be provided upon a family's demand. Some ethicists contend that treatment that merely preserves permanent unconsciousness should be considered to be futile and should not be provided regardless of the family's choice. As a society, we respect people's legal rights to refuse medical treatment, but are we equally committed to pay for extremely expensive treatment that most others would consider to be of no benefit?

In recent years, the Ombudsman's office has assumed a less confrontational posture and it is likely that alternate mechanisms of internal institutional review will be adopted by New Jersey's nursing homes, either singly or acting in concert with others. Ironically, just two months before the Conroy decision, the Medical Society of New Jersey had recommended that all nursing homes develop such a supportive care review process, but this was quickly forgotten in the aftermath of the Court's intervention.

Table. *Medical-legal considerations and processes in withholding or withdrawing life-sustaining treatment, based on New Jersey case law and statute.*

	Permanently Unconscious	Terminal Illness	Incurable Illness
Competent	—	A	B
Incompetent/ Advance Directive	C	D	E
Incompetent/No Advance Directive	F	G	H

A. Competent people have the right to decide for themselves. Two consultants may be necessary to confirm that the patient is properly informed.
B. A problematic category that raises the question of suicide.
C. Clear and convincing evidence of patient wishes is not required. A single qualified consultant required.
D. Death anticipated in six months or less. Rx would be futile in prolonged life or is likely only to prolong an imminent dying process. Requires consultation by a single qualified physician.
E. Burdens of Rx reasonably outweigh benefits, or imposition of Rx on an unwilling patient would be inhumane.
F. Focus is whether there is any reasonable likelihood of return to cognitive existence? Confirmation of prognosis needed by two neurologists as well as consultation with an ethics/prognosis committee.
G. Do the burdens of Rx outweigh benefits? Is there intractable pain?
H. Consider withholding treatment in the most unusual cases of burdens substantially outweighing benefits. In judging what is the patient's best interest, there should be a bias in favor of life. Consider patient's condition, prognosis, pain, and invasiveness of Rx. Ethics committee consultation is advisable.

LEGISLATIVE RESPONSE

As a byproduct of the Conroy decision, the state Legislature accepted the Supreme Court's challenge to develop broad statutory law concerning end-of-life decision making. Their initial response was to form a bioethics study commission that began its work early in 1986. Like the earlier President's Commission for the Study of Ethical Problems and Biomedical and Behavioral Research, New Jersey's Bioethics Commission had a striking underrepresentation of physicians; for most of its working life only 2 of 27 commissioners were practicing physicians. Not surprisingly, such a group was unconcerned with the historic traditions of the medical profession and was attuned to a new paradigm of doctors sharing decision-making authority with others.

After more than two years of study, dispute, and compromise over what it had thought would be "the easy issues," the commission published its findings in June 1988 and proposed two new statutes for the Legislature's consideration: the New Jersey Declaration of Death Act and the New Jersey Advance Directives for Health Care Act.[18] From the beginning, both bills were severely criticized, particularly by "right-to-life" groups. Much of the public debate was marked by inflammatory rhetoric and failure to distinguish between such disparate conditions as whole brain death and coma. Certain modifications eventually were adopted and both bills finally were approved by the Legislature in 1991.

The Declaration of Death Act concerned recognition of "whole

brain death" according to "currently accepted medical procedures" and gave statutory codification and detail to the New Jersey Supreme Court's Strachan decision of 1988 that had acknowledged the validity of the general concept.[19] Public discussions about the neurologic criteria to be employed were rancorous and seemed to tap a strong antiprofessional mood and fear by some that physicians might prematurely or inappropriately diagnose brain death. The approved statute required the New Jersey State Department of Health and the State Board of Medical Examiners to periodically update contemporary neurologic criteria so as to avoid erroneous or haphazard diagnosis.

When New Jersey's Legislature approved its advance directives statute in June 1991, the state and federal Supreme Courts, the United States Congress, 47 other state legislatures, and all major professional organizations already had endorsed the concept. By 1990, the federal Patient Self-Determination Act required health care institutions to provide all patients with written information explaining their rights to make medical decisions. New Jersey's new advance directives law goes beyond the federal requirement in that physicians as well as institutions have an affirmative obligation to inquire about the existence of an advance directive and to note in the medical record whether or not one exists.

It is unfortunate that it was felt necessary to mandate and legislate effective communication, but a laudatory effect of these new federal and state laws is likely to be that physicians will more actively engage their patients in treatment option discussions and will encourage them to formally document their preferences.

INSTITUTIONAL ETHICS COMMITTEES (IECs)

Physician-ethicist Mark Siegler, MD, has suggested that medical decision making has evolved through three successive ages of paternalism, autonomy, and bureaucracy.[20] In New Jersey, it seemed that all three ages have been operative simultaneously. An example of the latter is the IEC that originally was proposed in the Quinlan decision as a method to help "diffuse responsibility" in order to allay physicians' concerns about incurring liability if they were to eschew life-sustaining treatment.

New Jersey has had the longest experience of any state with IECs, but their purpose and the composition of their members continues to be a source of confusion and disagreement. Nonetheless, IECs have burgeoned throughout the nation and have assumed increasing involvement in three general areas: education, policy development, and prospective case review. In 1990, the New Jersey State Department of Health passed a regulation requiring all hospitals to maintain multidisciplinary IECs that would include representation by social workers, clergy, legal authorities, physicians, and nurses.

A task force of the Bioethics Commission considered these issues for more than two years and its debate provides useful insight into the new dynamics of group decision making. Some members asserted that when engaged in case review, the IEC's role should be strictly consultative and final authority should be shared by the physician and patient or surrogate. Others held that if physicians complied with the IECs "consultation," they should be granted immunity from liability. An inducement of legal immunity no doubt would attract many more cases for IEC review, but at the same time there would be a powerful incentive for physicians to defer to the committee's recommendation in difficult cases in order to protect themselves. In effect, the committee would be transformed from consultant to controller.

Some critics hold that it is premature to grant decision-making authority to IECs since "groupthink" may introduce new potential for abuse. Furthermore, depending upon the size and composition of the IEC, the balance of power could shift in favor of the nonphysician members. While some might favor such an alignment, it would radically transform the decision-making process in favor of collective reasoning. It is difficult to foresee to what extent external regulation and bureaucracy will further alter clinical practice in the future, but it is evident that there will be an increasing requirement for public scrutiny of decisions that formerly were the sole province of physicians.

WHERE ARE WE HEADING?

Societal changes during the past two decades have contributed to a distrust of authority figures in general, and of professionals in particular. Social historian David J. Rothman amplified this theme in his book, *Strangers at the Bedside*, suggesting that physicians have brought much of their present diminished status upon themselves through collective arrogance.[4] One of Mr. Rothman's more compelling points is that the medical profession has become estranged from mainstream society and the bonds that once tied physicians to their patients and to their communities have been replaced by professional isolation and exclusivity. As a result, physicians frequently are seen as strangers who cannot be trusted to exercise unilateral discretion over weighty life and death matters.

Whether or not Mr. Rothman's critique is balanced or fair, he is correct in suggesting that physicians too often are perceived as being self-serving. His analysis may seem harsh but no more so than the following startling confession made by the president of the American Medical Association (AMA), "The AMA's old style was to react and to be against things. But there has been a

philosophical change in our House of Delegates. We will be out front where the action is. We'll stop being just selfish and only thinking of our own welfare. If we start taking good care of our patients, they will take care of us."

CONCLUSION

Public policy development in New Jersey during the 15 years after the Quinlan decision differed from other states in several respects. This evolution substantially reflected the fact that many of the issues were openly debated in hearings both of the Bioethics Commission and in forums sponsored by the New Jersey Citizens Committee on Biomedical Ethics, a grassroots organization devoted to educating and involving the public in health policy making.

The following comments and caveats are derived from New Jersey's unique "experiment" particularly as it has transformed the dynamics of medical decision making:

1. Rather than being passive recipients of advance directives, physicians should initiate conversations with patients about their preferences in various clinical scenarios. In order to do this effectively, physicians must learn not only how to talk to patients, but how to become better listeners.

2. Laws and regulations in a pluralistic society should accommodate a spectrum of values. Medical choices and treatment plans should be framed in a broader context than the strictly medical model and should consider the patient's values and goals.

3. When decisions have mortal consequences, a formal procedural framework may be necessary. Nevertheless, sufficient discretionary space should be allotted so that the primary decision makers can function with reasonable privacy and freedom from bureaucracy.

4. The tone of regulatory or overview bodies should be supportive and educational rather than confrontational or punitive.

5. In the absence of any directives to the contrary, there should not be a reflex assumption that everything possible should be done to prolong life in every clinical circumstance. Some suggest that if there must be a burden of proof, it should be on those who would require life-sustaining treatment in incurable cases rather than the other way round.[21]

6. Institutional ethics committees are promising vehicles for promoting thoughtful decision making, but any temptation to delegate final responsibility to them should be resisted until there is sufficient evidence that collective multidisciplinary thinking represents a legitimate improvement over traditional processes.

7. The medical profession's role may have been diminished in authority, but the physician alone uniquely combines the knowledge, experience, and objectivity that are necessary to be the principal player in the arena of the bedside.

8. Physicians should attempt to restore their historic links to the general community by participating in such activities as legislative commissions, health care forums, and other civic affairs.

9. There should be a moratorium on further procedural innovations until enough time has passed to absorb the lessons of those changes that have been introduced in recent years. ■

Dr. Nevins is a member of the New Jersey Commission on Legal and Ethical Problems in the Delivery of Health Care; chairman of the Ethics Committee, New Jersey Chapter, American College of Physicians; and attending at Pascack Valley Hospital. The paper was submitted in October 1991 and accepted in December 1991. Address reprints requests to Dr. Nevins, 354 Old Hook Road, Westwood, NJ 07675.

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Carcinogenesis, Mutagenesis, Impairment of Fertility–A 2-year oral carcinogenicity study in rats with doses as high as 500 mg/kg/day (about 80 times the recommended daily therapeutic dose) showed no evidence of a carcinogenic effect. There was a dose-related increase in the density of enterochromaffin-like (ECL) cells in the gastric oxyntic mucosa. In a 2-year study in mice, there was no evidence of a carcinogenic effect in male mice, although hyperplastic nodules of the liver were increased in the high-dose males as compared with placebo. Female mice given the high dose of Axid (2,000 mg/kg/day, about 330 times the human dose) showed marginally statistically significant increases in hepatic carcinoma and hepatic nodular hyperplasia with no numerical increase seen in any of the other dose groups.The rate of hepatic carcinoma in the high-dose animals was within the historical control limits seen for the strain of mice used. The female mice were given a dose larger than the maximum tolerated dose, as indicated by excessive (30%) weight decrement as compared with concurrent controls and evidence of mild liver injury (transaminase elevations). The occurrence of a marginal finding at high dose only in animals given an excessive and somewhat hepatotoxic dose, with no evidence of a carcinogenic effect in rats, male mice, and female mice (given up to 360 mg/kg/day, about 60 times the human dose), and a negative mutagenicity battery are not considered evidence of a carcinogenic potential for Axid.

Axid was not mutagenic in a battery of tests performed to evaluate its potential genetic toxicity, including bacterial mutation tests, unscheduled DNA synthesis, sister chromatid exchange, mouse lymphoma assay, chromosome aberration tests, and a micronucleus test.

In a 2-generation, perinatal and postnatal fertility study in rats, doses of nizatidine up to 650 mg/kg/day produced no adverse effects on the reproductive performance of parental animals or their progeny.

Pregnancy–Teratogenic Effects–Pregnancy Category C–Oral reproduction studies in rats at doses up to 300 times the human dose and in Dutch Belted rabbits at doses up to 55 times the human dose revealed no evidence of impaired fertility or teratogenic effect; but, at a dose equivalent to 300 times the human dose, treated rabbits had abortions, decreased number of live fetuses, and depressed fetal weights. On intravenous administration to pregnant New Zealand White rabbits, nizatidine at 20 mg/kg produced cardiac enlargement, coarctation of the aortic arch, and cutaneous edema in 1 fetus, and at 50 mg/kg, it produced ventricular anomaly, distended abdomen, spina bifida, hydrocephaly, and enlarged heart in 1 fetus. There are, however, no adequate and well-controlled studies in pregnant women. It is also not known whether nizatidine can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Nizatidine should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers–Studies in lactating women have shown that 0.1% of an oral dose is secreted in human milk in proportion to plasma concentrations. Because of growth depression in pups reared by treated lactating rats, a decision should be made whether to discontinue nursing or the drug, taking into account the importance of the drug to the mother.

Pediatric Use–Safety and effectiveness in children have not been established.

Use in Elderly Patients–Healing rates in elderly patients were similar to those in younger age groups as were the rates of adverse events and laboratory test abnormalities. Age alone may not be an important factor in the disposition of nizatidine. Elderly patients may have reduced renal function.

Adverse Reactions: Worldwide, controlled clinical trials included over 6,000 patients given nizatidine in studies of varying durations. Placebo-controlled trials in the United States and Canada included over 2,600 patients given nizatidine and over 1,700 given placebo. Among the adverse events in these placebo-controlled trials, only anemia (0.2% vs 0%) and urticaria (0.5% vs 0.1%) were significantly more common in the nizatidine group. Of the adverse events that occurred at a frequency of 1% or more, there was no statistically significant difference between Axid and placebo in the incidence of any of these events (see package insert for complete information).

A variety of less common events were also reported; it was not possible to determine whether these were caused by nizatidine.

Hepatic–Hepatocellular injury (elevated liver enzyme tests or alkaline phosphatase) possibly or probably related to nizatidine occurred in some patients. In some cases, there was marked elevation (>500 IU/L) in SGOT or SGPT and, in a single instance, SGPT was >2,000 IU/L. The incidence of elevated liver enzymes overall and elevations of up to 3 times the upper limit of normal, however, did not significantly differ from that in placebo patients. All abnormalities were reversible after discontinuation of Axid. Since market introduction, hepatitis and jaundice have been reported. Rare cases of cholestatic or mixed hepatocellular and cholestatic injury with jaundice have been reported with reversal of the abnormalities after discontinuation of Axid.

Cardiovascular–In clinical pharmacology studies, short episodes of asymptomatic ventricular tachycardia occurred in 2 individuals administered Axid and in 3 untreated subjects.

CNS–Rare cases of reversible mental confusion have been reported.

Endocrine–Clinical pharmacology studies and controlled clinical trials showed no evidence of anti-androgenic activity due to nizatidine. Impotence and decreased libido were reported with similar frequency by patients on nizatidine and those on placebo. Gynecomastia has been reported rarely.

Hematologic–Anemia was reported significantly more frequently in nizatidine than in placebo-treated patients. Fatal thrombocytopenia was reported in a patient treated with nizatidine and another H_2-receptor antagonist. This patient had previously experienced thrombocytopenia while taking other drugs. Rare cases of thrombocytopenic purpura have been reported.

Integumental–Urticaria was reported significantly more frequently in nizatidine- than in placebo-treated patients. Rash and exfoliative dermatitis were also reported.

Hypersensitivity–As with other H_2-receptor antagonists, rare cases of anaphylaxis following nizatidine administration have been reported. Rare episodes of hypersensitivity reactions (eg, bronchospasm, laryngeal edema, rash, and eosinophilia) have been reported.

Other–Hyperuricemia unassociated with gout or nephrolithiasis was reported. Eosinophilia, fever, and nausea related to nizatidine have been reported.

Overdosage: Overdoses of Axid have been reported rarely. If overdosage occurs, activated charcoal, emesis, or lavage should be considered along with clinical monitoring and supportive therapy. The ability of hemodialysis to remove nizatidine from the body has not been conclusively demonstrated; however, due to its large volume of distribution, nizatidine is not expected to be efficiently removed from the body by this method.

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Compliance with New OSHA Bloodborne Standard

Kathleen Voldish, CLA (ASCP)

New Jersey physicians who have office staff giving injections, performing venipuncture, analyzing body fluids, or assisting with minor surgical procedures must comply with OSHA's bloodborne Standard. The Standard became effective on March 6, 1992.

On December 2, 1991, the Occupational Safety and Health Administration (OSHA) published the final bloodborne Standard in *The Federal Register* (1910.1030). The Standard was first proposed and released on May 30, 1989, and received over 3,000 comments. It is hoped this Standard will prevent more than 9,200 infections and 200 deaths among health care workers each year by limiting hazardous occupational exposure. The law provides guidance for creating and maintaining a safe working environment. Hepatitis B is the most common, serious bloodborne risk medical workers face. Although occupational HIV transmission is relatively rare, its lethal nature requires that every possible step be taken to prevent exposure. This Standard expands upon the "Hazardous Communication Standard of 1987" and the "Occupational Exposure to Hazardous Chemicals Standard of 1991," that cover physician and dental offices. Meeting these requirements is not optional. The effective date of this Standard was March 6, 1992. Any office where employees come in contact with human blood or other potentially infectious material must comply with this regulation. The key requirements of the Standard are:

Exposure control plan. An employer must formulate a written plan to identify procedures and tasks that involve exposure. This plan must specify who is at risk and specific ways to protect and to train persons at risk. The plan should be reviewed annually and should be accessible to employees and OSHA.

The Table lists the components of an exposure control plan, also called an infection control program (ICP).

Method of compliance. Universal precautions are mandated. Procedures to minimize needle sticks, procedures to minimize splashing and spraying of blood, schedules for cleaning and decontaminating work areas, and disposal of contaminated sharps and other regulated medical waste must be specified. Provisions for handling contaminated laundry (when applicable) must be stated. The employer must provide protective equipment such as gloves, laboratory coats (aprons), goggles, masks, eyewashes, mechanical pipettes, mouthpieces, and resuscitation bags to employees. Employers shall provide for cleaning of personal protective equipment and replace equipment that no longer is effective. Gloves are required for routine phlebotomies.

Hepatitis B vaccine. The Standard requires all employees exposed to blood to be offered a hepatitis B vaccine within ten days of employment. The employee may refuse the vaccine, but should sign a declination form if he refuses. This form should be maintained in the employee's personnel file. The employee, at a later date, may opt to receive the vaccine. Vaccinations shall be given according to recommendations for standard medical practice. Prescreening for this vaccination is not required as a condition of receiving the vaccine. This vaccine is to be offered at no cost to the employee.

Postexposure evaluation and followup. If an employee has been exposed, specific procedures for followup should be followed. The exposure must be documented and should include the circumstances and source of the exposure, as well as testing the source specimen for HIV and/or HBV infection. Followup steps could include a confidential medical evaluation, evaluation of any illness (if illness occurs), analysis of the employee's blood, and counseling, if indicated. All diagnoses must remain confidential. Medical evaluations must be available to OSHA. Records must be retained on each occupational exposure for the duration of

Table. *Components of an infection control program.*

1. Exposure Determination
2. Control Methods:
   - (A) Universal precautions
   - (B) Engineering controls
   - (C) Work practice controls
   - (D) Personal protective equipment
3. HBV vaccination
4. Postexposure evaluation and followup
5. Infectious waste disposal
6. Tags, labels, and bags
7. Housekeeping practices
8. Laundry practices
9. Training and education of employees
10. Recordkeeping

employment plus an additional 30 years.

Hazard communication. Biohazard warning labels must be affixed to any containers used to store or transport potentially infectious materials. Red bags may be used in place of labels in certain circumstances. Refrigerators or freezers used to store blood are to have biohazard symbols on the outside. Soiled laundry should be handled with universal precautions but does not need to be labelled. Employees must be informed of the meaning of various types of biohazard labels.

Housekeeping. The employer shall see that the worksite is maintained in a clean and sanitary condition. Disinfectants and cold sterilization products must be available. A schedule for cleaning must be written in the exposure control plan and followed; however, all areas and items should be cleaned whenever necessary. A 1:10 solution of household bleach may be used for general cleanup.

Information and training. The Standard mandates that a safety training program be offered within 90 days of the Standard's effective date. Safety training should be reviewed and updated annually with employees. Training should include information on the Standard, discussion of bloodborne diseases and transmission, exposure control practices, universal precautions, biohazard labels, hepatitis B vaccine, how to handle exposures, how to document exposures, and followup of exposure. It also would be advantageous to cover items required in previous OSHA Standards. The training may be informal but the instructor should be knowledgeable. Training records should be maintained in the employee's personnel file for three years.

Date of implementation. The exposure control plan must be completed within 60 days from March 6, 1992. The information and training requirements should be introduced to employees within 90 days of the Standard. All other provisions will be enforced within 120 days of the effective date.

CONCLUSION

The bloodborne Standard legally requires physicians and dentists to provide a safe working environment for employees. The Standard provides valuable protection and should not be taken lightly. Information packets about the Standard are available from OSHA to provide guidance in meeting the requirements. Physicians needing assistance are advised to secure the services of a safety instructor or qualified consultant to aid them in meeting this Standard. The overriding principle is that the requirements of the Standard must be met. ■

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Ms. Voldish is a POL consultant and the New Jersey representative for the American Society of Clinical Pathologists. This paper was submitted in December 1991 and accepted in January 1992. Address reprint requests to Ms. Voldish, POL Consultants, 1150 Concord Drive, Haddonfield, NJ 08033.

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Endoscopic Diagnosis of Anorectal Melanoma

Kenneth P. Rubin, MD
Dilip Ghanekar, MD
Ivan A. Friedrich, MD
Vincent S. Panella, MD

Symptoms of anorectal melanoma commonly are attributed to hemorrhoids. The authors believe recognition of the sigmoidoscopic appearance will allow the physician to distinguish this condition from the more common anorectal disorders.

We present a case of endoscopically diagnosed anorectal melanoma. Malignant melanoma of the anorectum is a rare disease accounting for 0.4 to 1.6 percent of all melanomas. Since the symptoms of melanoma in this region are similar to benign anorectal conditions,[2] the recognition of the sigmoidoscopic appearance is important for diagnosis. The endoscopic appearance of this entity is not described in major textbooks on gastrointestinal endoscopy.[3,4] We believe the tumor has a characteristic endoscopic appearance.

CASE REPORT

A 77-year-old woman was evaluated due to rectal bleeding and weight loss. A barium enema performed four months previously revealed diverticulosis. Physical examination showed no inguinal lymphadenopathy, hepatomegaly, or splenomegaly. Rectal examination showed a firm polypoid lesion, about 2.5 cm in diameter on the posterolateral aspect of the anorectum. Flexible sigmoidoscopy revealed a bluish, firm, polypoid, friable lesion 2.5 cm in diameter at the dentate line (Figures 1 and 2). The remainder of the sigmoid and descending colon was normal. Biopsy of the mass revealed melanoma.

DISCUSSION

The common symptoms of anorectal melanomas include rectal bleeding, anal pain, anal mass, and constipation.[5] Symptoms of the tumor commonly are ascribed to hemorrhoids.[2] Anorectal melanomas on sigmoidoscopy characteristically are firm, friable, polypoid masses, blue-black in color, and usually arise at the dentate line. The surface may be ulcerated. The treatment of a patient's lesions primarily is surgical.

We believe that the characteristic blue-black color of this polypoid lesion will allow the endoscopist to distinguish anorectal melanoma from more common disorders of that region. Biopsy should be done to confirm the diagnosis. ■

Editor's note. Most physicians will see few, if any, melanomas of the anorectal canal during their practice years. The description of the tumor as given by the authors and its location at the dentate line match previous descriptions in the surgical literature.

If melanoma is suspected and clinical evaluation of the patient suggests possible control by abdominoperineal type of resection, it probably is prudent to time the biopsy in close association with

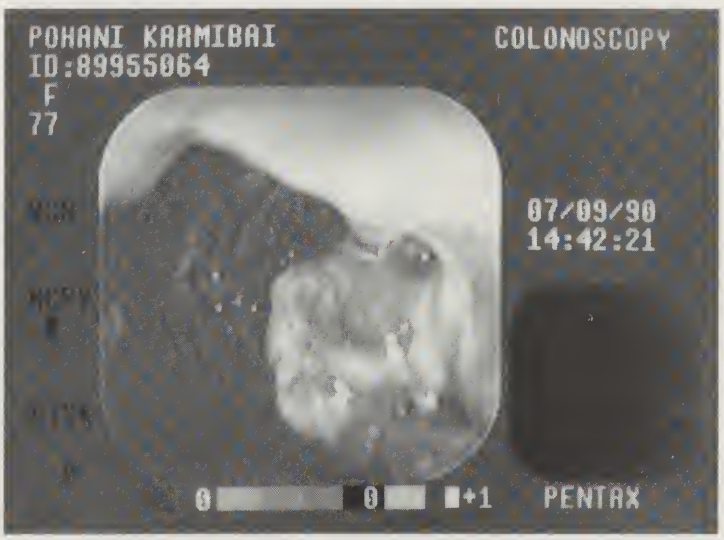


Figure 1. Bluish, firm, polypoid, friable lesion, 2.5 cm in diameter.



Figure 2. Bluish, firm, polypoid friable lesion, 2.5 cm in diameter.

the proposed operation to decrease chances of growth and dissemination of the tumor. □

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The authors are affiliated with the Department of Medicine, Division of Gastroenterology, Mt. Sinai School of Medicine, CUNY, and Englewood Hospital, Englewood. The paper was submitted in December 1991 and accepted in January 1992. Address reprint requests to Dr. Rubin, 420 Grand Avenue, Englewood, NJ 07631.



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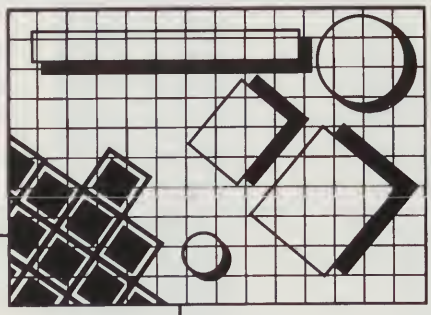
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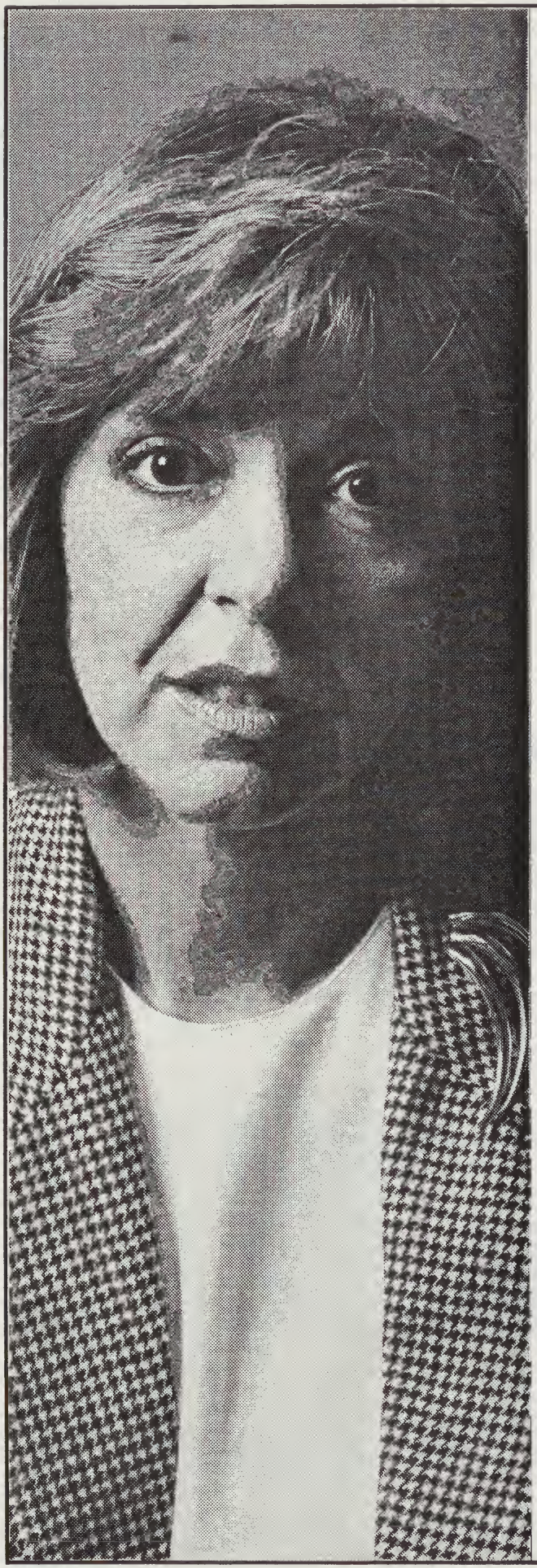
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He was only in the hospital four days. How could his bill be $52,000?

A: Blame it on DRG's.

Q: DRG's? What are they?

A: The DRG, or diagnosis-related group, system was introduced by government in the early 1980's as an experiment in hospital reimbursement.

Q: What do they do?

A: By having insurers pay a set amount based on the patient's medical diagnosis, DRG's were supposed to bring fairness and cost efficiency to the health care system. They haven't.

Q: Why not?

A: The DRG system, when combined with the uncompensated care system, is so complex it often serves to bring about the very situations it was designed to prevent. (Like billing an insurance company $52,000 for what amounted to just over $5,000 in actual hospital charges.) The system is also too rigid. It discourages hospitals from finding less expensive ways to care for patients.

Q: What can I do about it?

A: Write your state legislators and demand a fair and reasonable system for reimbursing hospitals.

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1st District	2 years	Hilda B. Templeton, MD, Essex
2nd District	2 years	No Candidate
4th District	2 years	James P. O'Neill, MD, Monmouth
5th District	2 years	No Candidate
Public Health		
1st District	2 years	No Candidate
2nd District	2 years	John P. Mudry, MD, Bergen
3rd District	2 years	Lawrence D. Frenkel, MD, Middlesex
4th District	2 years	Mary F. Campagnolo, MD, Burlington
Public Relations		
1st District	2 years	Giovanni Lima, MD, Essex
3rd District	2 years	Leticia V. DeCastro, MD, Middlesex
4th District	2 years	Aram M. Sarajian, MD, Ocean
6th Member	2 years	Paul M. DiLorenzo, Monmouth
Standing Committees		
Annual Meeting	2 years	John P. Mudry, MD, Bergen
	2 years	Jeffrey M. Solomon, MD, Cumberland
Finance and Budget	2 years	Frank L. Redo, MD, JD, Salem
	2 years	No Candidate
Medical Education	2 years	Anthony P. DeSpirito, MD, Monmouth
	2 years	Paul C. Royce, MD, Monmouth
Membership Services	*1 year	No Candidate
	2 years	Robert L. Maggs, MD, Monmouth
	2 years	Yale C. Shulman, MD, Hudson
Publication	2 years	M. Arif Hashmi, MD, Camden
	2 years	Morris Soled, MD, Hudson

*Unexpired term of Patricia G. Klein, MD, who resigned January 6, 1992.

REVISED
HOUSING APPLICATION

226th ANNUAL MEETING
THE MEDICAL SOCIETY OF NEW JERSEY
MAY 3-6, 1992

TRUMP TAJ MAHAL CASINO/RESORT
1000 BOARDWALK AT VIRGINIA AVENUE, ATLANTIC CITY, NJ 08401
RESERVATION DEPARTMENT 1/800/825-8786

(Please Print)

Name _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Business Phone _____

Sharing With _____

Date of Arrival _____ Time _____

Date of Departure _____ Time _____

A one-night deposit (equivalent to room rate) is required with all reservation requests. Please send check or money order payable to the **TRUMP TAJ MAHAL CASINO/RESORT** or complete the following:

Card # _____ Type _____ Exp. Date _____

SCHEDULE OF RATES SUBJECT TO 13% TAX
☐ SINGLE **$115** ☐ DOUBLE **$115**
Extra Person **$25**
☐ One-Bedroom Suite **$275 per day**
☐ One-Bedroom Hospitality Suite **$300 per day**

Check-out time is 12 NOON. Rooms may not be available for check-in until after 3 P.M. Check-in time on Sundays is 5 P.M. FORTY-EIGHT (48) HOURS NOTICE OF CANCELLATION is required for a full refund.

PARKING: FREE PARKING TO REGISTERED GUESTS. One car per room.

☐ Check if Official Delegate _____ County _____

PLEASE NOTE: Effective March 1, 1992, Atlantic City Casino hotels must begin levying a $2 per room, per night hotel room use as recently legislated by the state of New Jersey.

The proceeds from the fees collected pursuant to this legislation shall be paid into a special fund that will be established and held by the Atlantic City Convention Center Authority. Amounts in the special fund shall be expended by the Convention Center Authority solely for the purposes of promoting tourism, conventions, resorts, and casino gaming.

****

MAIL THIS APPLICATION TO:

Reservations
Trump Taj Mahal Casino/Resort
1000 Boardwalk at Virginia Avenue
Atlantic City, New Jersey 08401
Tel: **1/800/825/8786**

DOCTORS' NOTEBOOK

TRUSTEES' MINUTES

A regular meeting of the Board of Trustees was held on February 9, 1992, at the executive offices in Lawrenceville. Detailed minutes are on file with the secretary of your county society. A summary of significant actions follows.

President's Report. Noted the following items: Walter J. Kahn, MD, was commended by the New Jersey Senate for his outstanding record of professional excellence; David E. Swee, MD, will serve as MSNJ's representative on the task force for the drafting of the State Health Plan chapter on primary care; women physicians are providing new leadership in MSNJ activities; tort reform in New Jersey is being discussed; concerns of the New Jersey Association of Osteopathic Physicians and Surgeons are similar issues for MSNJ; copies of MSNJ's response to Phase I of the State Health Plan, as well as any relevant new materials as they are processed, will be forwarded to members of the Board, county medical societies, and interested persons; and problems facing hospital emergency rooms due to the fact that emergency rooms are the main access to medical care for indigent patients.

Specialty Reports. Received reports from the University of Medicine and Dentistry, Stanley S. Bergen, Jr, MD; New Jersey Hospital Association, Louis Scibetta; MSNJ Auxiliary, Marion Geib; and the Academy of Medicine of New Jersey, Gerald Shapiro, MD.

Executive Director's Report.

1. Licensing Board Decision. Directed Steven I. Kern, Esquire, to file a petition for certification in this case concerning the biennial application for license renewal issued by the State Board of Medical Examiners; Mr. Kern has done so and the state is opposing the motion.

2. Petrocco versus Dover General Hospital. Affirmed President Riggs' authorization to intervene in this suit brought against Dover General Hospital by a chiropractor requesting damages and demanding admission to the medical staff.

3. Stewart (Copeland) versus Sullivan. Decided that a report and recommendation would be sought from Judge Herbert J. Stern, to assess the suit's probability of success as well as to determine what role MSNJ should play as a possible advocate of contractual rights, in this case where Dr. Lois Copeland has proposed an open enrollment group insurance plan for New Jersey elderly as an alternative to Medicare Part B.

4. Extension of Grace Period for New Visit Codes. Noted that the new evaluation codes have been extended for one calendar month, to February 29, 1992, per notification of the Health Care Financing Administration.

5. Proposed Adoption of a Joint Medical-Legal Agreement. Recommended that the Executive Committee review the proposal for a joint medical-legal agreement, along with the proposed modifications, for report back to the Board of Trustees.

6. MSNJ Intervention Requested in a Malpractice Case. Voted to enter the case amicus and that the firm of Stern & Greenberg be engaged as MSNJ's counsel; the case involved a verdict in excess of several million dollars with at least a million and a half dollars of the damages attributable to emotional distress.

Council on Legislation. Approved the following recommendation:

That the Board of Trustees take action to initiate legislation that will provide for the appointment of physicians recommended by MSNJ to all health care boards in the state of New Jersey.

And, approved and will submit to the House of Delegates for concurrence, the following recommendation:

That the Executive Committee be empowered to authorize negotiated positions in legislation that MSNJ actively is supporting or opposing.

Council on Medical Services. Approved the following recommendations:

That, where possible, issues relating to the Council on Medical Services should be referred to the Council on Medical Services, and ad hoc or subcommittees should be formed under the auspices of the Council, rather than the formation of ad hoc committees at any other level.

That members of MSNJ who are not members of the Council may be included as consultants, at the discretion of the chairman.

Council on Mental Health. Voted that the issue of managed care concerning psychiatric patients be referred to the Council on Medical Services for further study and report back to the Board of Trustees as soon as possible, so the Board can make recommendations based upon their report:

That the Board of Trustees refer the issue of managed care concerning psychiatric patients to the Council on Public Relations. The Council on Mental Health would request the help and cooperation of the Council

on Public Relations to educate the public.

Council on Medical Education. Approved the "Guidelines for Commercial Support of Continuing Medical Education."

Committee on International Medical Graduates. Approved the following recommendation:

That MSNJ support efforts by the State Board of Medical Examiners to revise the Medical Practice Act to allow greater flexibility in reviewing the premedical education of international medical graduates.

Committee on Finance and Budget. Approved the following recommendations:

1. That the first year of full membership be assessed at the rate of 50 percent of regular dues.
2. That any physician employed and/or practicing less than 20 hours per week, by request, may be assessed at the rate of 50 percent of regular dues.
3. That there be a waiver of dues assessment for a year of maternity leave, if so requested.
4. That the AMA Delegation be requested to recommend that similar policies be adopted for AMA membership.

Unfinished Business. Noted that the AMA in cooperation with the American Medical Peer Review Association (AMPRA) and other health care organizations, is in the process of developing "Principles of Medical Record Documentation," in an effort to reduce the number of hassles physicians face in dealing with PROs and Medicare carriers because of so-called errors in documentation.

New Business. Endorsed Dr. Robert J. Weierman's candidacy for vice-chairman of the AMA Hospital Medical Staff Section Governing Council. □

MSNJ AUXILIARY

On a Sunday afternoon in February, three of Delaware Valley's largest newspapers sent reporters and photographers to cover the "Chocolate Challenge" sponsored by the Gloucester County Medical Society Auxiliary. This unique fundraiser was organized to raise money to purchase a much-needed piano for the county's Shady Lane Nursing Home. Held in the lobby of a Woodbury bank, the event attracted over 100 chocolate aficionados who sampled an array of confections submitted for competition by professional and amateur bakers, candymakers, and restaurateurs in southern New Jersey.

The impressive fundraiser received full-page press coverage. Newspaper headlines read: "Divine Chocolate"; "Delicious Idea To Raise Funds For Good Cause"; "Chocolate Challenge Gives Lift to Gloucester County Medical Society Auxiliary's Charity Fund." Although the articles dealt mainly with the chocolate entries and the competition, the brief but positive recognition of the Gloucester County Medical Society Auxiliary and its admirable cause was a welcome bonus. And it will be no surprise if those same photographers attend the "piano presentation" at Shady Lane Nursing Home.

On the national level, the AMA Auxiliary is receiving press coverage of its campaign against family violence. Launched in June 1991, in conjunction with the AMA, the three-part program aims to educate the public about family violence, to support victims of violence, and to provide physicians with resources for patients who are victims of violence. An AMA media symposium, held in New York City, attracted reporters from across the country to publicize the facts about the national epidemic. The one-day pro-

Women in Medicine

Monday, May 4, 1992
12:15 P.M.

Topaz Room—Section B
Trump Taj Mahal Casino/Resort
Atlantic City, New Jersey

Guest Speaker:

Christine Todd Whitman
"Women Physicians in Public Affairs"

Ms. Whitman attained national prominence in 1990 when she almost unseated Senator Bill Bradley. Now that Ms. Whitman is a proven vote-getter, she is widely considered the frontrunner for the 1993 Republican nomination for governor of New Jersey.

Sponsored by MSNJ Committee on Women in Medicine
Luncheon charge: $30

Reservation Deadline: April 17, 1992

Send form and check made out to MSNJ
Attention: Marge Bolling
2 Princess Road, Lawrenceville, NJ 08648

"Women Physicians in Public Affairs"

Name: _____

Address: _____

Phone: _____ No. reservations_____

gram featured such experts as United States Surgeon General Antonia C. Novello, MD; Richard D. Krugman, MD, director of the C. Henry Kempe National Center on Child Abuse and Neglect; Richard J. Gelles, PhD, director of the Family Violence Research Program at the University of Rhode Island; and David L. Chadwick, MD, director of the Center for Child Protection in San Diego. ☐ Marion H. Geib

UMDNJ NOTES

Medical school honors founders and civic leaders. They gathered in a single small brick building to teach a handful of students. Their laboratories were in an old barracks. From the efforts of this group of pioneering biomedical scientists 25 years ago emerged today's UMDNJ-Robert Wood Johnson Medical School. These early trailblazers were joined along the way by leaders who spurred its growth and nurtured its progress.

These leaders were honored at a recent awards dinner commemorating the 25th anniversary of the school's first entering class. Fifty-three early faculty members were cited along with three civic leaders who have championed both the medical school and its missions of education, research, and health care.

The event, at the medical school's Piscataway campus, also honored Ralph S. Larsen, chairman and chief executive officer of Johnson & Johnson, New Brunswick, State Senator John A. Lynch (D-17th District) of New Brunswick, and Dr. Richard C. Reynolds of Princeton, executive vice-president, The Robert Wood Johnson Foundation, and former dean of the medical school.

The 53 faculty honored included professors and department chairmen who served in the 1960s and early 1970s. They were heralded as "adventurers who created the first curriculum, planned the first buildings, and taught the first students." Each received framed citations stating: "Your bold vision, commitment to excellence, and adaptability to ever-changing conditions set the drumbeat to which we successors have marched."

Cancer Institute gains federal grant. The Cancer Institute of New Jersey, a collaborative effort of UMDNJ-Robert Wood Johnson Medical School and the New Brunswick Affiliated Hospitals (NBAH) will receive a cancer center planning grant from the National Cancer Institute (NCI). The grant, expected to be more than $700,000 over the next three years, was announced by Congressman Bernard J. Dwyer (D-6th District).

The state of New Jersey has a population of more than seven million people and ranks fourth in cancer mortality. Despite these statistics, New Jersey is the only state in the industrial northeast without a comprehensive, university-based cancer center. The Cancer Institute of New Jersey was established as the state's only university-based cancer center.

Researchers test new sickle cell treatment. A new drug treatment for sickle cell anemia that could eliminate half the painful crises that mark the disease is being tested at UMDNJ-New Jersey Medical School, Newark. Dr. Pedro Gascon, associate professor of medicine and director of hematology at the medical school, is conducting the study at the

1992 MSNJ Annual Meeting Proposed Daily Schedule

Saturday, May 2, 1992

3:30 p.m. Board of Trustees' Meeting

Sunday, May 3, 1992

8:00 a.m. Registration Opens
9:30 a.m. Message Center Opens
10:00 a.m. Educational Program
11:30 a.m. Exhibits Open
2:00 p.m. House of Delegates
3:30 p.m. Reference Committee Meetings

Monday, May 4, 1992

8:00 a.m. Registration Opens
8:00 a.m. Message Center Opens
8:30 a.m. Exhibits Open
9:00 a.m. House of Delegates (Election)
12:00 noon Golden Merit Award Ceremony and Reception
2:30 p.m. Reference Committee Meetings
5:00 p.m. JEMPAC Political Forum
5:45 p.m. JEMPAC Wine and Cheese Reception
6:30 p.m. Camden County Medical Society Reception

Tuesday, May 5, 1992

8:00 a.m. Registration Opens
8:00 a.m. Message Center Opens
8:30 a.m. Exhibits Open
9:00 a.m. House of Delegates
1:30 p.m. House of Delegates
2:00 p.m. Exhibits Close
7:00 p.m. Inaugural Reception and Dinner

school's Sickle Cell Center, 1 of 14 research sites nationwide.

The new treatment involves hydroxyurea, a drug used to lower high white blood cell counts in leukemia patients. Hydroxyurea also has been found to stimulate production of fetal hemoglobin—a red blood cell component rarely found in adults.

Fertility center moves to expanded new quarters. The University Center for Reproductive Endocrinology and Fertility—the only medical school-based infertility service in central New Jersey—has expanded its state-of-the-art facilities in new quarters at 303 George Street in New Brunswick. Part of UMDNJ-Robert Wood Johnson Medical School, the Center offers comprehensive services for male and female reproductive problems, including the newest in vitro and donor egg techniques. It also provides diagnosis and treatment of endometriosis, menstrual disorders, and other hormonal disorders of women.

Another procedure, done at the hospital, is gamete intrafallopian transfer (GIFT), which allows fertilization to take place in the woman's body when sperm and retrieved eggs are introduced into the fallopian tubes. Almost 200 babies—including the 130 in vitro babies—have been conceived as the result of all of the assisted procedures.

UMDNJ launches innovative faculty practice plan for nurses. An innovative faculty practice plan for nurses, one of only a handful of such programs in the nation, has been launched by UMDNJ. The plan allows full-time faculty of UMDNJ's nursing education program to spend a percentage of their time in clinical nursing practice at health care facilities outside the University.

The plan's benefit is twofold: It will help ease critical shortages of top-flight nurses in New Jersey's health care system and will insure that UMDNJ nursing faculty maintains sharp professional skills and remains up-to-date on emerging issues in nursing. ☐ Stanley S. Bergen, Jr, MD

AMNJ REPORT

The Academy of Medicine of New Jersey (AMNJ) again will participate as a sponsoring organization for the Clara Barton Medical Service Award. The Award recognizes outstanding effort and contributions to the welfare of human life. The project is part of a major statewide effort to improve the image of New Jersey and to recognize New Jerseyans who have accomplished many great and important advances in a wide variety of fields. The formal ceremony will be held in the fall and the governor will recognize those honored. AMNJ is soliciting recommendations and, in conjunction with our co-sponsor, the American Red Cross, will present three nominees to the award committee.

The second annual statewide pediatric hematology/oncology conference, "Update in Neonatal Hematology," sponsored by AMNJ and the five Valerie Fund Children's Centers in New Jersey will be held on Friday, April 24, 1992, at the Hyatt Regency Hotel, New Brunswick. This year's symposium will focus on common hematological problems during the newborn period. Lectures will concentrate on practical issues that face the neonatologist and the practitioner who cares for newborns.

The latest information on transfusion therapy, red cell abnormalities, platelet abnormalities, clotting problems, anemia, and cancer will be presented. The identification of the risks and clotting problems of neonatal thrombocytopenia will be addressed as well as the workup and treatment of these problems. Guidelines on the proper use of human blood products including gamma globulin will be discussed. For further information or to obtain a brochure, contact Pat Walter at the executive offices.

The Academy will sponsor a symposium, "Sleep Disorders: Recognition, Evaluation, and Treatment" on Wednesday, April 29, 1992, at Mercer Medical Center, Trenton. A distinguished group of certified sleep specialists, diplomates of the American Board of Sleep Medicine, will explore the diagnostic approach to patients with sleep problems and the treatment of common sleep disorders and their medical complications. For further information, contact Joyce Fleming at the executive offices. ☐ Gerald Shapiro, MD, President

MEDICARE PHYSICIAN'S LIAISON GROUP: MEETING REPORT

Use of modifiers. The surgery bundling or global fee provides the use of modifiers to enable the surgeon to claim for reasonable additional services. Except for minor complications such as aspiration of a seroma, services are covered by these modifiers. We urge you to read them thoroughly and to submit appropriate data. Do not forego payment for a service because of the effort needed to correctly code. If physicians fail to use these codes, they will be deleted.

Following are five examples of useful modifiers:

–24—Unrelated Evaluation and Management Service by the Same Physician During a Postoperative Period: The physician may need to indicate that an evaluation and management service was performed during a postoperative period for a reason(s) unrelated to the original procedure. This circumstance may be reported by adding the modifier "–24" to the appropriate level of E/M service, or the separate five-digit modifier 09924 may be used.

–25—Significant, Separately

Identifiable Evaluation and Management Service by the Same Physician on the Day of a Procedure: The physician may need to indicate that on the day a procedure or service identified by a CPT code was performed, the patient's condition required a significant, separately identifiable E/M service above and beyond the usual preoperative and postoperative care associated with the procedure that was performed. This circumstance may be reported by adding the modifier "–25" to the appropriate level of E/M service, or the separate five-digit modifier 09925 may be used.

–56—Preoperative Management Only: When one physician performs the preoperative care and evaluation and another physician performs the surgical procedure, the preoperative component may be identified by adding the modifier "–56" to the usual procedure number or by use of the separate five-digit modifier code 09956.

–76—Repeat Procedure by Same Physician: The physician may need to indicate that a procedure or service was repeated subsequent to the original service. This circumstance may be reported by adding the modifier "–76" to the repeated service or the separate five-digit modifier code 09976 may be used.

–77—Repeat Procedure by Another Physician: The physician may need to indicate that a basic procedure performed by another physician had to be repeated. This situation may be reported by adding modifier "–77" to the repeated service or the separate five-digit modifier code 09977 may be used.

Bundling of surgical procedures. Neither Medicare nor the Health Care Financing Administration (HCFA) will provide details of the extent of the length of followup with the global surgical fee. In order to obtain this information, the physician will have to request the *Federal Register* that contains this information. This document can be ordered by sending your request to: U.S. Government Printing Office, Order and Information Desk, Washington, DC, 20402-9329. Specify the issue, November 25, 1991, Volume 56, No. 227, Part II, requesting Stock No. 069-001-00037-8; the cost of each copy is $1.50.

Evaluation in management code. Medicare continues to reinforce the fact that there is no crosswalk between the old and new evaluation and management codes. It is essential that physicians are well versed in the minutiae of these requirements. We are quite sure that the carrier will monitor up-coding.

Independent procedures. In the past, surgical procedures identified as independent procedures would be paid for only if they were carried out alone and not in combination with other procedures. As of January 1, when performed with other procedures, so-called independent procedures no longer will be bundled. You are advised to use a modifier 51 (multiple procedures) to describe the service.

Consultation. Consultation obtained within a multipractitioner group is appropriate and the consulting physician may take over care of the patient. Provided there is documentation, the consultation will be regarded as a new patient rather than an established patient in this situation.

Assistant at surgery. Assistant at surgery remains a problem in that numerous major procedures have been denied assistance fees because they fall within the 5 percent minimum national average. For the most part, these remain major procedures that are carried out at tertiary care institutions with residents' assistance. Pennsylvania Blue Shield will bring this to the attention of HCFA. □

Ian D. Samson, MD

NEW MEMBERS

The Medical Society of New Jersey would like to welcome the following members to the Society:

Atlantic County

Dean L. De Broekert, MD
Fernando J. Delasotta, MD
Chris R. Giamporcaro, MD
Scott A. Hernberg, DO
Kenneth L. Weiss, MD
William M. Wixted, MD
Richard Zalman, MD

Bergen County

Rocco A. Barbieri, MD
Alex Y. Bekker, MD
Gregory J. Bonavita, MD
Kenneth A. Citak, MD
David Cooper, MD
Kaye E. Davis, MD
Joel S. Federbush, MD
Kenneth A. Giuffre, MD
Marvin I. Gottlieb, MD
Andrew E. Hummel, DO
Anna M. Korkis, MD
Robin H. Levat, MD
Bernard P. Newman, MD
Thomas R. Peterson, MD
Barbara A. Phillips, MD
Rick J. Pumill, MD
Arnold H. Rabinowitz, MD
Michael H. Reilly, MD
Fred F. Rezvani, MD
John I. Rho, MD
Nancy A. Rothenberg, DO
Peter H. Schmaus, MD
Ronald E. Strobel, MD
Gary D. Wasserman, MD
Alvin Wertentheil, MD
Ignatios S. Zairis, MD

Burlington County

Otto B. Brdlik, DO
Stephen G. Friedhoff, MD
Thomas R. Hedges, Jr, MD
David S. Hulbert, MD
Linda R. Miller, MD
Andrew B. Sattel, MD

Camden County

Ashokkumar R. Babaria, MD
Lou-Anne M. Beauregard, MD
Douglas J. DiPaola, MD
Sandra L. Fischer, MD
Fredric Gerewitz, MD
Dov Gorshein, MD
Jeffrey H. Kramer, MD
Joseph A. Libby, MD
Kevin Lukenda, DO
William F. Muhr, Jr, MD
Alfio K. Pennisi, MD

Maurie D. Pressman, MD
Marc H. Rabin, MD
James F. Vander, MD
Reynaldo Velasco, MD
Kent J. Volosin, MD

Cape May County

Sherilyn A. Bredin, MD
Zaheer A. Farooqui, MD
Randell A. Nuschke, MD
Jeng-Ren Wang, MD
Joseph R. Zerbo, DO

Cumberland County

Per M. Montero-Pearson, MD

Essex County

Neil H. Adelman, MD
Rosemary B. Albano, MD
Nicholas G. Baranetsky, MD
David M. Berowitz, MD
Steven J. Clark, MD
Vivian K. Chou, MD
Steven B. Cohen, MD
Aloysius B. Cuyjet, MD
John S. D'Aconti, DO
Barry E. DiBernardo, MD
Mark P. Faber, MD
Jonathan E. Goldstein, MD
Curtis A. Johnson, Jr, MD
Iftekhar S. Kadri, MD
Edward T. Kalmar, MD
Virginia I. Lay, MD
Ruy V. Lourenco, MD
Komala D. Mallampati, MD
Madhavi N. Maniar, MD
Kenneth P. Miller, MD
Louis J. Molinaro, MD
Dinesh R. Patel, MD
Shirish C. Patrawalla, MD
Bradley A. Radwaner, MD
Michele B. Reichstein, MD
Robert A. Ruffini, MD
Theodore P. Sgambati, Jr, MD
Donna M. Smith, MD
Scott A. Spiro, MD
Jeffrey S. Upperman, MD
Edward J. Vecchione, DO
Cory D. Vergilio, MD
Mitchell Vogel, MD
Jacob M. Zeffren, MD
Kapukalar A. Ziyaaudhin, MD

Gloucester County

Joseph J. Mike, MD

Hudson County

Ira J. Ellen, MD
Howard J. Hirsch, MD
Theodore O. Witter, MD

Hunterdon County

John J. Jacobson, MD
Paul S. Phillips, MD
Terry E. Shlimbaum, MD

Mercer County

Lily Aggarwal, MD
Dennis Balgowan, MD
John M. Benson, MD
James P. Callahan, MD
Leonard G. Dennick, MD
Donald F. Denny, Jr, MD
Michael J. Kane, MD
Scott A. Kolander, MD
Arnold L. Lentnek, MD
Steven M. Orland, MD
Robert H. Potts, Jr, MD
Roy M. Prager, MD
David N. Rosvold, MD
Darell M. Shaffer, MD
Alan Tipermas, MD

Middlesex County

Ferdinand Q. Alcaide, MD
Masoud Bamdad, MD
Joseph G. Barone, MD
Richard A. Drachtman, MD
Neil A. Feldstein, MD
Frederick D. Foti, Jr, MD
Charles D. Franco, MD
Howard C. Lederman, MD
Robert B. Levin, MD
Steven Santiago, MD
Norman S. Sorkin, MD
Maria S. Uray, MD

Monmouth County

Katherine Angeles, MD
Gordon D. Donald, MD
Jeffrey C. Fahl, MD
Rao S. Gourkanti, MD
Kelly C. Hammond, MD
Peter M. Mezzacappa, MD
Bruce Patsner, MD
Rajagopalan Sivaprasad, MD
Robert A. Slutsky, MD

Morris County

Kathryn P. Alberti, MD
Robert J. Cole, MD
Glenn A. Davis, MD
Thomas F. De Blasio, MD
Samuel M. Edwards, MD
Leonor Forero-Briggs, MD
Leonard J. Moss, DO
Keith M. Muir, MD
Donald J. Mykulak, MD
Lavi Oud, MD
Donna B. Vining, DO
Stephen L. Winters, MD

Ocean County

Juan D. Bermudez, MD
Charles H. Geneslaw, MD
Rita R. Gunawan, MD
Robert M. Mako, DO
Sheela U. Vinod, MD

Passaic County

Nirmala K. Chintapalli, MD
Baseem T. Daoud, MD
Juan De la Cruz Nova, MD
Michael R. Kane, MD
Leonard M. Zaretski, MD

Somerset County

Anthony J. Catanese, MD
Varonica L. Dixon, MD
Raymond P. Eskow, MD

Sussex County

Ernest B. Leibov, MD

Union County

Jose M. Arrunategui, MD
Eric B. Chan, MD
Jyh-Shyan Chen, MD
Steven H. Diamond, MD
Steven G. Dorsky, MD
Michael Engelberg, MD
Kevin E. Gallagher, MD
Robert D. Huang, MD
Howard Kessler, MD
William F. Kottler, MD
Elynne B. Margulis, MD
Linda W. McClintic, MD
Richard O. Nelson, MD
Elyse L. Seidner-Joseph, MD
Norman A. Shoenfeld, MD
Mitchell S. Silverman, MD
Frances D. Yim, MD
David H. Yu, MD

ARE YOU MOVING?

If so, please send a change of address to *NEW JERSEY MEDICINE*, Medical Society of New Jersey, Two Princess Road, Lawrenceville, NJ 08648, at least six weeks before you move.

New Address _____

City _____ State _____ Zip _____

PHILADELPHIA HEART INSTITUTE

at Presbyterian Medical Center

Cardiology Update

designed for the physician and provides an intensive survey of the current status of clinical cardiology . . .

Wednesday, May 6, 1992

Aggressive Cardiac Procedures: Catheter Intervention or Coronary Bypass Surgery

Moderator: William J. Untereker, M.D.

3:00-3:30 Balloon and laser angioplasty, stents, atherectomy: For whom, why, complications, short and long-term results—***Alexander Stratienko, M.D.***

3:30-4:00 Coronary surgery for the geriatric patient: What are the risks and the results?—***James D. Sink, M.D.***

4:00-5:00 Case Presentations—***Bradford Lin, M.D.***
Panel Discussion—***Michael Adesman, M.D., William J. Untereker, M.D., Frederic J. Weber, M.D.***

- *Case Presentations and Panel Discussions*
- *CME Credits**
- *No Registration Fee*
- *Call for Reservations 215-662-8627*

Scheie Auditorium
Presbyterian Medical Center
39th & Market Streets
Philadelphia, Pennsylvania 19104

The Philadelphia Heart Institute at Presbyterian Medical Center is an affiliate of the University of Pennsylvania.

**Presbyterian Medical Center designates this continued medical education activity for 2 credit hours in Category I of the Physicians' Recognition Award of the American Medical Association and the Pennsylvania Medical Society Membership requirement. Nine sessions, 18 credits.*

CONTINUING EDUCATION

INFECTIOUS DISEASE

May

1 **Inter-Jersey Infectious**
8 **Disease Rounds**
15 Hackensack Medical Center,
22 Newark Beth Israel Medical
29 Center, Saint Joseph's Hospital and Medical Center, Overlook Hospital, and University Hospital
(UMDNJ and AMNJ)

1 **Changing Characteristics of HIV Infection**
8:30-10:30 A.M.—Trump Taj Mahal Casino/Resort, Atlantic City
(AMNJ and MSNJ)

1 **Identification and Management of the HIV Indeterminant Infant**
8-9 A.M.—Barnert Hospital, Paterson
(AMNJ and NJDOH)

1 **Diagnosis and Treatment of AIDS**
12 Noon-1 P.M.—South Jersey Hospital System, Bridgeton
(AMNJ and NJDOH)

6 **AIDS Spring Conference**
8:30-11:30 A.M.—MSNJ Annual Meeting, Trump Taj Mahal Casino/Resort, Atlantic City
(AMNJ and MSNJ)

7 **Changing Characteristics of HIV Infection**
8:30 A.M.-1:45 P.M.—Sheraton Newark Airport, Elizabeth
(AMNJ)

11 **Identification and Management of the HIV Indeterminant Infant**
8-9 A.M.—Kennedy Memorial Hospital, Stratford
(AMNJ and NJDOH)

11 **AIDS Spring Conference**
8:30 A.M.-1:45 P.M.—Radisson Hotel, Newark Airport
(AMNJ and NJDOH)

11 **Identification and Management of Asymptomatic HIV Infection**
7-8 P.M.—Wallkill Valley Hospital, Sussex
(AMNJ and NJDOH)

12 **AIDS Spring Conference**
8:30 A.M.-1:45 P.M.—Sheraton Poste Inn, Cherry Hill
(AMNJ and NJDOH)

13 **Diagnosis and Treatment of AIDS**
4-5 P.M.—St. Joseph's Hospital, Clifton
(AMNJ and NJDOH)

15 **Identification and Management of the HIV Indeterminant Infant**
1-2 P.M.—The Medical Center at Princeton, Princeton
(AMNJ and NJDOH)

15 **Identification and Management of Asymptomatic HIV Infection**
9-10 A.M.—St. Francis Medical Center, Trenton
(AMNJ and NJDOH)

19 **Diagnosis and Treatment of AIDS**
11:30 A.M.-12 Noon—Rahway Hospital, Rahway
(AMNJ and NJDOH)

19 **Identification and Management of the HIV Indeterminant Infant**
12 Noon-1 P.M.—St. Mary's Hospital, Hoboken
(AMNJ and NJDOH)

20 **Identification and Management of the HIV Indeterminant Infant**
8-9 A.M.—Warren Hospital, Phillipsburg
(AMNJ and NJDOH)

20 **Hepatitis**
2:30-3:30 P.M.—Ancora Psychiatric Hospital, Hammonton
(AMNJ and NJDOH)

21 **Identification and Management of Asymptomatic HIV Infection**
12 Noon-1 P.M.—Hospital Center at Orange, Orange
(AMNJ and NJDOH)

21 **Changing Characteristics of HIV Infection**
8:30 A.M.-1:45 P.M.—Sheraton Poste Inn, Cherry Hill
(AMNJ)

27 **Identification and Management of Asymptomatic HIV Infection**
12:30-1:30 P.M.—Christ Hospital, Jersey City
(AMNJ and NJDOH)

27 **Identification and Management of Asymptomatic HIV Infection**
2:30-3:30 P.M.—Ancora Psychiatric Hospital, Hammonton
(AMNJ and NJDOH)

June

3 **Identification and Management of Asymptomatic HIV Infection**
12 Noon-1 P.M.—Union Hospital, Union
(AMNJ and NJDOH)

9 **Identification and Management of the HIV Indeterminant Infant**
9:30-10:30 A.M.—MCOSS Nursing Services, Red Bank
(AMNJ and NJDOH)

9 **Identification and Management of the HIV Indeterminant Infant**
8-9 A.M.—Newcomb Medical Center, Vineland
(AMNJ and NJDOH)

19 **Identification and Management of the HIV Indeterminant Infant**
12 Noon-1 P.M.—Medical Center of Ocean County, Point Pleasant
(AMNJ and NJDOH)

MEDICINE

May

1 **Diabetic Nephropathy**
8:30-9:30 A.M.—Chilton Memorial Hospital, Pompton Plains
(AMNJ)

3- **MSNJ Annual Meeting**
6 All day—Trump Taj Mahal Casino/Resort, Atlantic City

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For information on meetings or submission or presentations of papers, contact Symposium Chairman, Prof. Y. Omura, M.D., Sc.D., 800 Riverside Drive (8-I) New York, NY 10032 Tel: (212) 781-6262 (10 am to 10 pm 7 days a week) or (212) 928-0658, Co-chairman, Prof. A.W. Cook, MD (516) 877-1821, or Bro. Michael Losco (212) 920-0162.

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(MSNJ)

3 **Advance Directive, Legislation of Clinical Practice**
12:15-1:15 P.M.—MSNJ Annual Meeting, Trump Taj Mahal Casino/Resort, Atlantic City
(MSNJ and AMNJ)

5 **Oral Raccoon Rabies Vaccine**
12:15-1:15 P.M.—Health & Agriculture Building, Trenton
(AMNJ)

6 **Medical Problems of the Elderly**
11:30 A.M.-12:30 P.M.—Hamilton Hospital, Hamilton
(AMNJ)

6 **Physicians, Their Hearts, and Type A Coronary Prone Behavior**
9:15-11:45 A.M.—MSNJ Annual Meeting, Trump Taj Mahal Casino/Resort, Atlantic City
(AMNJ and MSNJ)

6 **Endocrinology Monthly Meeting**
6-9 P.M.—Holiday Inn, Newark Airport, Newark
(AMNJ)

6 **Dermatology Grand Rounds**
13 6-9 P.M.—Rutgers Community
20 Health Plan, New Brunswick
27 *(UMDNJ)*

6 **Endocrinology Grand Rounds**
13 11:30 A.M.-1 P.M.—VA Medical
20 Center, East Orange
27 *(AMNJ)*

6 **Interhospital Endocrine**
13 **Rounds**
20 3:30-5:30 P.M.—Newark Beth
27 Israel Medical Center, University Hospital, VA Medical Center, and United Hospitals Medical Center
(AMNJ)

6 **Intensive Review of Internal**
13 **Medicine**
20 4-7 P.M.—University Hospital, Medical Education Building, New Brunswick
(UMDNJ and AMNJ)

6 **National Health Objectives Year 2000**
10:30-11:30 A.M.—Christ Hospital, Jersey City
(AMNJ)

6 **Urinary Tract Infection**
10:30-11:30 A.M.—St. Mary's Hospital, Passaic
(AMNJ)

7- **Women and Children:**
9 **Preventive Medicine III**
All day—Trump Regency, Atlantic City
(Cooper Hospital/University Medical Center)

8 **Medical Problems of the Elderly**
12 Noon-1 P.M.—Memorial Hospital of Burlington County, Mount Holly
(AMNJ)

11 **Alzheimer's Disease**
1-2 P.M.—New Lisbon Developmental Center, New Lisbon
(AMNJ)

12 **Medical Problems of the Elderly**
11 A.M.-12 Noon—Raritan Bay Medical Center, Old Bridge
(AMNJ)

13 **Medical Problems of the Elderly**
8:15-9:15 A.M.—Newcomb Medical Center, Newcomb
(AMNJ)

13 **Diabetic Retinopathy**
10:30-11:30 A.M.—St. Mary's Hospital, Passaic
(AMNJ and NJDOH)

13- **Annual Scientific Meeting:**
15 **Emergency Medicine**
Trump Plaza, Atlantic City
(American College of Emergency Physicians and AMNJ)

15 **Troubled Youth**
8:30 A.M.-4:15 P.M.—Holiday Inn, Jamesburg
(AMNJ and SERV Centers of NJ)

15 **OSHA Regulations for Dentists**
8 A.M.-2 P.M.—MSNJ Headquarters, Lawrenceville
(AMNJ and Academy of General Dentistry)

15 **Conference on Medical Care for People with Developmental Disabilities**
9 A.M.-3:30 P.M.—Rutgers University, Cook Campus Center, New Brunswick
(Mainstreaming Medical Care of ARC/NJ and AMNJ)

19 **Geriatric Roving Symposia**
11 A.M.-12 Noon—MSNJ Headquarters, Lawrenceville
(AMNJ)

19 **General Membership Meeting**
All day—Ramada Inn, Clark
(NJ State Society of Anesthesiologists)

19 **Annual Morris Saffron Lecture**
4:20-9 P.M.—Nassau Club, Princeton
(AMNJ)

20 **QA Criteria Development**
10:30-11:30 A.M.—St. Mary's Hospital, Passaic
(AMNJ)

20 **Physician Office Laboratory Workshop**
All day—Center for Health Affairs, Princeton
(ASCP)

20 **Diabetes in Pregnancy**
1:30-2:30 P.M.—Central New Jersey Medical Group, Somerset
(AMNJ)

20 **Health Care Reform in New Jersey**
12:15-1:15 P.M.—Health & Agriculture Building, Trenton
(AMNJ)

21- **Pediatric Life Support**
22 8 A.M-4 P.M.—UMDNJ-Medical Science Building, Newark
(UMDNJ)

June

3 **Endocrinology Monthly Meeting**
6-9 P.M.—Holiday Inn, Newark Airport, Newark
(AMNJ)

3 **Endocrinology Grand Rounds**
10 11:30 A.M.-1 P.M.—VA Medical
17 Center, East Orange
24 *(AMNJ)*

3 **Interhospital Endocrine**
10 **Rounds**
17 3:30-5:30 P.M.—Newark Beth
24 Israel Medical Center, University Hospital, VA Medical Center, and United Hospitals Medical Center
(AMNJ)

10 **Seizure Disorders and Rational Use of Anticonvulsants**
8 A.M.-3:45 P.M.—The Mansion on Main Street, Voorhees
(AMNJ)

11 **Diabetic Retinopathy**
1:30-2:30 P.M.—Essex County Hospital Center, Essex
(AMNJ and NJDOH)

12- **Annual Meeting: New Jersey**
13 **Gastroenterological Society and New Jersey Society for Gastrointestinal Endoscopy**
Seasons Resort and Conference Center at Great Gorge, McAfee

15 **Diabetic Retinopathy**

Hahnemann University

Department of Medicine Grand Rounds
Wednesdays 8:30 a.m.-9:30 a.m.

April-May 1992

APRIL 1992

April 1, 1992
CURRENT CONTRACEPTIVE MANAGEMENT: BENEFITS AND RISKS
Richard A. Baker, M.D.
Professor and Vice Chairman
Department of Obstetrics and Gynecology
Hahnemann University

April 8, 1992
PRINCIPLES GOVERNING THE USE OF THROMBOLYTIC AGENTS
Burton E. Sobel, M.D.
Lewin Professor of Medicine
Director, Cardiovascular Division
Washington University School of Medicine
St. Louis, MO

April 15, 1992
INTRAVASCULAR CATHETER-RELATED INFECTIONS
Dennis G. Macki, M.D.
Professor of Medicine
Chief, Section of Infectious Diseases
University of Wisconsin Medical School
Madison, WI

April 22, 1992
NUTRITIONAL SUPPORT IN THE CRITICAL CARE UNIT
Rosemarie L. Fisher, M.D.
Associate Professor of Medicine
Division of Digestive Diseases
Department of Internal Medicine
Yale University School of Medicine
New Haven, CT

ENDOSCOPIC MANAGEMENT OF BILIARY TRACT DISORDERS
Jerome H. Siegel, M.D.
Associate Professor of Medicine
Mt. Sinai School of Medicine
Chief, Endoscopy Unit
Beth Israel Medical Center North
New York, NY

April 29, 1992
DEVELOPMENT OF SKIN SUBSTITUTES
Richard L. Spielvogel, M.D.
Professor of Medicine and Dermatology
Director, Division of Dermatology
Hahnemann University

MAY 1992

May 6, 1992
HYPERTENSION IN PREGNANCY
Robert W. Schrier, M.D.
Professor and Chairman
Department of Medicine
University of Colorado School of Medicine
Denver, CO

May 13, 1992
INVASIVE VERSUS NONINVASIVE ASSESSMENT OF VALVULAR HEART DISEASE
Richard Gorlin, M.D.
Professor and Chairman
Department of Medicine
Mt. Sinai School of Medicine
New York, NY

May 20, 1992
PARANEOPLASTIC ENDOCRINE SYNDROMES
Kenneth L. Becker, M.D., Ph.D.
Professor of Medicine and Physiology
Director, Division of Endocrinology
George Washington University Medical
Center and VA Medical Center
Washington, DC

May 27, 1992
GUILLAIN-BARRÉ-STROLLE SYNDROME
Michael Sherman, M.D.
Assistant Professor of Medicine
Director, Pulmonary Function Laboratory
Division of Allergy, Critical Care & Pulmonary Medicine
Hahnemann University
Seth Tarras, M.D.
Assistant Professor of Neurology
Director, EMG Laboratory
Director, ALS Center
Department of Neurology
Hahnemann University
Scott Hessen, M.D.
Assistant Professor of Medicine
Clinical Electrophysiology Laboratory
Likoff Cardiovascular Institute
Hahnemann University

Hahnemann University Department of Medicine
Wednesday Medical Seminar Series
8:30 a.m.-3:30 p.m.

April 22, 1992
UPDATE IN GASTROENTEROLOGY, NUTRITION, AND ENDOSCOPY

May 5-6, 1992
HYPERTENSION AND KIDNEY DISEASE

Seminar Director:
Allan B. Schwartz, M.D.
Professor of Medicine
Director, Continuing Medical Education for the Department of Medicine

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1-2 P.M.—New Lisbon Developmental Center, New Lisbon

5-6 **44th Annual Meeting**
Trump Plaza Hotel and Casino, Atlantic City
(NJ Obstetrics and Gynecological Society)

17 **Neurosurgical Emergencies**
10:30-11:30 A.M.—St. Mary's Hospital, Passaic
(AMNJ)

24 **Geriatric Roving Symposia**
2:30-3:30 P.M.—Trenton Psychiatric Hospital, Trenton
(AMNJ)

24 **Prevention of LEA**
11:30 A.M.-12:30 P.M.—Hamilton Hospital, Hamilton
(AMNJ)

ONCOLOGY AND RADIATION ONCOLOGY

May

13 **Joint Meeting: Head and Neck Oncology Section and Radiation Oncology Section**
6:30-9 P.M.—The Manor, West Orange
(AMNJ)

21 **Tumor Board Conference**
12:15-1:15 P.M.—Mercer Medical Center, Trenton
(Mercer Medical Center)

June

3 **Bone Marrow Transplantation**
6-10 P.M.—The Hyatt Regency, New Brunswick
(AMNJ)

18 **Tumor Board Conference**
12:15-1:15 P.M.—Mercer Medical Center, Trenton
(Mercer Medical Center)

PSYCHIATRY

June

3 **Altered States: Dreams, Sleep, and Dissociation**
All day—Carrier Foundation, Belle Mead
(Carrier Foundation)

17 **Psychiatry Medication Interactions**
2:30-3:30 P.M.—Ancora Psychiatric Hospital, Hammonton
(AMNJ)

RADIOLOGY

May

21 **MRI Conference and Case Presentation**
7:30-9:30 P.M.—Saint Barnabas Medical Center, Livingston
(Radiological Society of New Jersey and Diagnostic Radiology Section, AMNJ)

21 **Radiology Lecture**
1:30-5 P.M.—Saint Barnabas Medical Center, Livingston
(Saint Barnabas MC)

June

10 **Nuclear Medicine**
10:30-11:30 A.M.—St. Mary's Hospital, Passaic
(AMNJ)

SURGERY AND ITS SPECIALTIES

April

4 **Annual Meeting**
9 A.M-1 P.M.—Nassau Inn, Princeton
(NJ Society of Plastic and Reconstructive Surgeons)

8 **New Wrinkles in Facial Cosmetic Surgery**
10:30-11:30 A.M.—St. Mary's Hospital, Passaic
(AMNJ)

UROLOGY

May

6 **William P. Burpeau Award and Lecture**
The Manor, West Orange
(Urology Section, AMNJ)

6 **Urinary Tract Infection**
10:30-11:30 A.M.—St. Mary's Hospital, Passaic
(AMNJ)

June 8-12th, 1992

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IN MEMORIAM

HENRY E. CARMAN

Seventy-three-year-old Henry Edward Carman, MD, passed away on November 15, 1991. Dr. Carman was born on March 21, 1918, in Brooklyn, New York. He attended Jefferson Medical College, Pennsylvania, earning a medical degree in 1943. After serving as a major in the United States Army from 1943 to 1946, Dr. Carman received his New Jersey medical license in 1946. Dr. Carman was director at Holy Name Hospital, Teaneck, and on the medical staff at Englewood Hospital. He was a surgeon with a general practice in Teaneck. Dr. Carman was a member of our Bergen County component and of the American Medical Association; a diplomate of the American Board of Family Practice; and a fellow of the American College of Angiology. Dr. Carman resided in Teaneck and Oradell.

WILLIAM R. FINNEGAN, JR

We regret to announce the death of William Robert Finnegan, Jr, MD, on November 12, 1991. Dr. Finnegan was born in New Brunswick on February 20, 1914. He resided in New Brunswick and Cranford, and in Myrtle Beach, South Carolina. Dr. Finnegan attended Temple University School of Medicine, Philadelphia, earning a medical degree in 1942, and he received a New Jersey medical license the following year. Then he served as a captain in the United States Army Medical Corps from 1943 to 1946, at Cushing General Hospital, Framingham, Massachusetts, and at the 102nd and 91st General Hospitals in Britain and Belgium. He completed residencies at St. Peter's Medical Center, New Brunswick, and at Bellevue Hospital, New York, and an internship at Kings County Hospital, New York. Dr. Finnegan specialized in anesthesiology. He was an anesthesiologist at Elizabeth General Medical Center from 1954 to 1980, and at Fitkin Memorial Hospital, Neptune, for four years. Dr. Finnegan was a member of our Union and Middlesex County components and of the American Medical Association; a diplomate of the American Board of Anesthesiology; and a fellow of the American College of Anesthesiologists.

SIDNEY GELMAN

We have received word of the death of Sidney Gelman, MD, on November 4, 1991, at the grand age of 85. Dr. Gelman was born in Brooklyn on August 16, 1906. In 1934, Dr. Gelman was awarded a medical degree from the University of Maryland School of Medicine, Baltimore. After completing an internship at Barnert Memorial Hospital, Paterson, and residencies at Sydenham Hospital and Union Memorial Hospital, both in Baltimore, Dr. Gelman received his New Jersey medical license in 1938. Dr. Gelman, a pediatric allergist, maintained a practice in Paterson and was affiliated with Barnert Memorial Hospital. Dr. Gelman was a member of the American Medical Association and of our Passaic County component; a diplomate of the American Board of Allergy and Immunology and of the American Board of Pediatric Allergy; a fellow of the Association for the Advancement

of Psychotherapy, of the American Association for Clinical Immunology and Allergy, and of the American College of Allergy and Immunology. Dr. Gelman was a United States Army veteran of World War II. He resided in Paterson and retired to Hallandale, Florida.

HEZEKIAH NICODEMUS

Eighty-six-year-old Hezekiah Nicodemus, MD, passed away on October 22, 1991. Dr. Nicodemus was born in India on November 12, 1904. After being awarded a medical degree from College of Physicians and Surgeons, Bombay, India, in 1931, Dr. Nicodemus practiced at Mission Hospital, Kakinada, South India, until 1941. From 1941 to 1951, Dr. Nicodemus maintained a general practice in Vishakapatnam, South India. He completed residencies at Methodist Hospital, Greenpoint Hospital, and Bethel Hospital, all in New York, and an internship at Greenpoint Hospital. In addition, Dr. Nicodemus completed a fellowship at French Hospital, New York. An anesthesiologist, Dr. Nicodemus practiced at Kingston Government Hospital, Jamaica; the former Margaret Hague Maternity Hospital, Jersey City; St. Mary's Hospital, New York; and St. Mary's Hospital, Orange. Dr. Nicodemus was a member of our Essex County component and of the American Medical Association.

LOUIS E. ROSIELLO

We regret to announce the death of Louis Ernest Rosiello, MD, who passed away on August 31, 1991. He was 82 years old. Dr. Rosiello was born in New York City in 1910. He attended New York Medical College, New York, and earned a medical degree in 1935. In 1946, Dr. Rosiello was awarded his New Jersey medical license. Dr. Rosiello was an otolaryngologist. He practiced in Vineland and was an attending at Newcomb Hospital, Vineland. Dr. Rosiello was a diplomate of the American Board of Otolaryngology, and a member of our Cumberland County component and of the American Medical Association. Dr. Rosiello resided in Vineland. He served in the United States Air Force during World War II.

HARRY A. H. SCHACHTER

At the grand age of 96, Harry Alton Hastings Schachter, MD, passed away on August 6, 1991; he was born on March 15, 1895, in Atlanta, Georgia, and resided in Rumson and Dahlonega, Georgia. Dr. Schachter attended Emory University School of Medicine, Atlanta, and was awarded a medical degree in 1919. In 1921, Dr. Schachter received his New Jersey medical license. Dr. Schachter was a neuropsychiatrist in Essex County. He was a member of our Essex County component, of the Academy of Medicine of New Jersey, and of the American Medical Association. Dr. Schachter served in the United States Navy Medical Corps during World War II.

ALEXANDER C. SZOT

Word has been received of the death of retired family practitioner and anesthesiologist Alexander Charles Szot, MD, on November 5, 1991, at the age of 73. Dr. Szot was born in Clifton on July 11, 1918. A 1944 graduate of Georgetown University School of Medicine, Washington, DC, Dr. Szot completed an internship at St. Mary's Hospital, Passaic. Dr. Szot maintained a practice in Harrison and Lyndhurst. He also was on staff at St. Mary's Hospital, Passaic, and served as the hospital's treasurer. He was a

member of our Bergen County component and of the American Medical Association. Dr. Szot resided in Lyndhurst and Rutherford. He served as a captain in the United States Army during World War II.

GISELA H. UCKO

At the age of 70, psychiatrist Gisela Hedwig Ucko, MD, died on December 10, 1991. Dr. Ucko was born in Germany on September 8, 1921. She attended Johann-Wolfgang-Goethe University, Frankfurt, Germany, and was awarded a medical degree in 1945. Dr. Ucko received her New York and New Jersey medical licenses in 1954 and 1957, respectively. She completed an internship at Christ Hospital, Jersey City, and residencies at Christ Hospital and Essex County Hospital Center, Cedar Grove. Dr. Ucko practiced in Teaneck and Ridgewood; she also was affiliated with Essex County Mental Hygiene Clinic; Essex County Guidance Center, East Orange; Pequannock Valley Mental Health Center; Mental Health Care Center of Passaic; Valley Hospital, Ridgewood; and the former Harrison S. Martland Memorial Hospital, Newark. In addition, she was a school psychiatrist for the Orange public school system; completed a fellowship at the Postgraduate Center for Mental Health, New York; and was medical director of Mount Carmel Guild Guidance Institute, Union City, and of North Essex Child Guidance Clinic. Dr. Ucko was a member of our Essex and Bergen County components. Dr. Ucko resided in Summit and Glen Rock.

MARTIN H. WEITBERG

Lindenwold family practitioner Martin Harry Weitberg, MD, died on November 2, 1991. He was 65 years old. Dr. Weitberg was born on January 9, 1926, in Philadelphia. He attended Hahnemann Medical College, graduating with a medical degree in 1954. The following year he received his New Jersey medical license. Dr. Weitberg practiced in Lindenwold for 35 years. Dr. Weitberg was on staff at West Jersey Hospital, Voorhees. He was a member of our Camden County component and of the American Medical Association; a diplomate of the American College of Family Practice; and a fellow of the American Academy of Family Practice. During World War II, Dr. Weitberg served in the United States Navy.

EDITORIAL CRITERIA

CONTENT

NEW JERSEY MEDICINE is the official organ of the Medical Society of New Jersey. The goals are educational and informational. All material published is copyrighted by the Medical Society of New Jersey.

The educational contents of each issue appear as scientific articles, based on research, original concepts relative to epidemiology of disease, and treatment methodology; case reports; review articles; clinical notes; state of the art reports; and special articles, that include evaluations, policy and position papers, and reviews of nonscientific subjects. Other topics include professional liability commentary; critical narration; medical history; pediatric briefs; nutrition update; and opinions. Editorials are prepared by the editor and by guest contributors on timely and relevant subjects. The Doctors' Notebook section contains organizational and administrative items from the Medical Society of New Jersey and from the community. Letters to the editor and book reviews are welcome and will be published as space permits.

The principal aim in the preparation of a contribution should be relevance to diagnosis and treatment and to the education of patients and professionals. Preference will be given to authors from New Jersey and to out-of-state lecturers submitting a suitable manuscript based on a presentation made to an audience in New Jersey.

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Submit two manuscripts that must be typewritten and double spaced on 8½" by 11" paper. Statistical methods used in articles should be identified.

The title page should include the full name, degrees, and affiliations of all authors, and the name and address of the author to whom reprint requests and correspondence should be sent.

The author should submit a 30-word abstract to be used at the beginning of the article.

Tables must be typewritten and double spaced on separate 8½" by 11" sheets, with a title and number. Symbols for units should be confined to column headings, and abbreviations should be kept to a minimum.

Illustrations should be professional quality, black-and-white glossy prints. The name of the author, figure number, and the top of the figure should be noted on a label attached to the back of each illustration. When photographs of patients are used, the subjects should not be identifiable or publication permission, signed by the subject or responsible person, must be included with the photograph. Material taken from other publications must give credit to the source.

Generic names should be used with proprietary names indicated parenthetically or as a footnote with the first use of the generic name. Proprietary names of devices should be indicated by the registration symbol—®.

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References should not exceed 35 citations except in review articles, and should be cited consecutively by numbers in parentheses at the end of the sentence. The style of *NEW JERSEY MEDICINE* is that of *Index Medicus:*

1. Goldwyn RM: Subcutaneous mastectomy. *NJ MED* 74:1050-1052, 1977.

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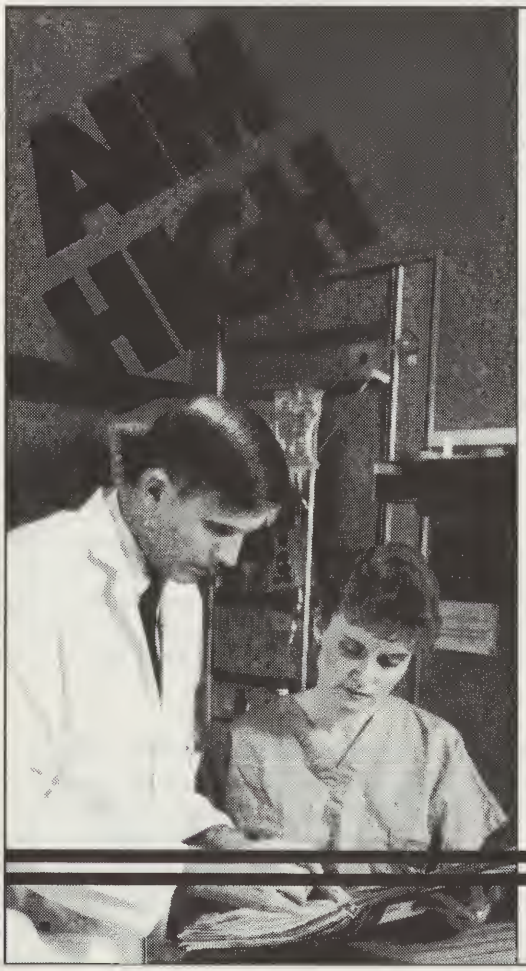
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Zantac® Tablets
ranitidine HCl/Glaxo 150 mg tablets bid

WHEN ACID REFLUX ERUPTS

Zantac® 150 Tablets **BRIEF SUMMARY**
(ranitidine hydrochloride)

Zantac® 300 Tablets
(ranitidine hydrochloride)

Zantac® Syrup
(ranitidine hydrochloride)

The following is a brief summary only. Before prescribing, see complete prescribing information in Zantac® product labeling.

INDICATIONS AND USAGE: Zantac® is indicated in:
1. Short-term treatment of **active duodenal ulcer.** Most patients heal within 4 weeks.
2. **Maintenance therapy** for duodenal ulcer patients at reduced dosage after healing of acute ulcers.
3. The treatment of **pathological hypersecretory conditions** (e.g., Zollinger-Ellison syndrome and systemic mastocytosis).
4. Short-term treatment of **active, benign gastric ulcer.** Most patients heal within 6 weeks and the usefulness of further treatment has not been demonstrated.
5. Treatment of **gastroesophageal reflux disease (GERD).** Symptomatic relief commonly occurs within 1 or 2 weeks after starting therapy. Therapy for longer than 6 weeks has not been studied.

In active duodenal ulcer; active, benign gastric ulcer; hypersecretory states; and GERD, concomitant antacids should be given as needed for relief of pain.

CONTRAINDICATIONS: Zantac® is contraindicated for patients known to have hypersensitivity to the drug.

PRECAUTIONS:

General: 1. Symptomatic response to Zantac® therapy does not preclude the presence of gastric malignancy.
2. Since Zantac is excreted primarily by the kidney, dosage should be adjusted in patients with impaired renal function (see DOSAGE AND ADMINISTRATION). Caution should be observed in patients with hepatic dysfunction since Zantac is metabolized in the liver.

Laboratory Tests: False-positive tests for urine protein with Multistix® may occur during Zantac therapy, and therefore testing with sulfosalicylic acid is recommended.

Drug Interactions: Although Zantac has been reported to bind weakly to cytochrome P-450 *in vitro,* recommended doses of the drug do not inhibit the action of the cytochrome P-450-linked oxygenase enzymes in the liver. However, there have been isolated reports of drug interactions that suggest that Zantac may affect the bioavailability of certain drugs by some mechanism as yet unidentified (e.g., a pH-dependent effect on absorption or a change in volume of distribution).

Increased or decreased prothrombin times have been reported during concurrent use of ranitidine and warfarin. However, in human pharmacokinetic studies with dosages of ranitidine up to 400 mg per day, no interaction occurred; ranitidine had no effect on warfarin clearance or prothrombin time. The possibility of an interaction with warfarin at dosages of ranitidine higher than 400 mg per day has not been investigated.

Carcinogenesis, Mutagenesis, Impairment of Fertility: There was no indication of tumorigenic or carcinogenic effects in lifespan studies in mice and rats at dosages up to 2,000 mg/kg per day.

Ranitidine was not mutagenic in standard bacterial tests (*Salmonella, Escherichia coli*) for mutagenicity at concentrations up to the maximum recommended for these assays.

In a dominant lethal assay, a single oral dose of 1,000 mg/kg to male rats was without effect on the outcome of two matings per week for the next 9 weeks.

Pregnancy: ***Teratogenic Effects: Pregnancy Category B:*** Reproduction studies have been performed in rats and rabbits at doses up to 160 times the human dose and have revealed no evidence of impaired fertility or harm to the fetus due to Zantac. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

Nursing Mothers: Zantac is secreted in human milk. Caution should be exercised when Zantac is administered to a nursing mother.

Pediatric Use: Safety and effectiveness in children have not been established.

Use in Elderly Patients: Ulcer healing rates in elderly patients (65 to 82 years of age) were no different from those in younger age-groups. The incidence rates for adverse events and laboratory abnormalities were also not different from those seen in other age-groups.

ADVERSE REACTIONS: The following have been reported as events in clinical trials or in the routine management of patients treated with Zantac®. The relationship to Zantac therapy has been unclear in many cases. Headache, sometimes severe, seems to be related to Zantac administration.

Central Nervous System: Rarely, malaise, dizziness, somnolence, insomnia, and vertigo. Rare cases of reversible mental confusion, agitation, depression, and hallucinations have been reported, predominantly in severely ill elderly patients. Rare cases of reversible blurred vision suggestive of a change in accommodation have been reported.

Cardiovascular: As with other H_2-blockers, rare reports of arrhythmias such as tachycardia, bradycardia, atrioventricular block, and premature ventricular beats.

Gastrointestinal: Constipation, diarrhea, nausea/vomiting, abdominal discomfort/pain, and rare reports of pancreatitis.

Hepatic: In normal volunteers, SGPT values were increased to at least twice the pretreatment levels in 6 of 12 subjects receiving 100 mg q.i.d. intravenously for 7 days, and in 4 of 24 subjects receiving 50 mg q.i.d. intravenously for 5 days. There have been occasional reports of hepatitis, hepatocellular or hepatocanalicular or mixed, with or without jaundice. In such circumstances, ranitidine should be immediately discontinued. These events are usually reversible, but in exceedingly rare circumstances death has occurred.

Musculoskeletal: Rare reports of arthralgias.

Hematologic: Blood count changes (leukopenia, granulocytopenia, thrombocytopenia) have occurred in a few patients. These were usually reversible. Rare cases of agranulocytosis, pancytopenia, sometimes with marrow hypoplasia, and aplastic anemia and exceedingly rare cases of acquired immune hemolytic anemia have been reported.

Endocrine: Controlled studies in animals and man have shown no stimulation of any pituitary hormone by Zantac® (ranitidine HCl) and no antiandrogenic activity, and cimetidine-induced gynecomastia and impotence in hypersecretory patients have resolved when Zantac has been substituted. However, occasional cases of gynecomastia, impotence, and loss of libido have been reported in male patients receiving Zantac, but the incidence did not differ from that in the general population.

Integumentary: Rash, including rare cases suggestive of mild erythema multiforme, and, rarely, alopecia.

Other: Rare cases of hypersensitivity reactions (e.g., bronchospasm, fever, rash, eosinophilia), anaphylaxis, angioneurotic edema, and small increases in serum creatinine.

OVERDOSAGE: Information concerning possible overdosage and its treatment appears in the full prescribing information.

DOSAGE AND ADMINISTRATION: (See complete prescribing information in Zantac® product labeling.)

Active Duodenal Ulcer: The current recommended adult oral dosage is 150 mg or 10 mL (2 teaspoonfuls equivalent to 150 mg of ranitidine) twice daily. An alternate dosage of 300 mg or 20 mL (4 teaspoonfuls equivalent to 300 mg of ranitidine) once daily at bedtime can be used for patients in whom dosing convenience is important. The advantages of one treatment regimen compared to the other in a particular patient population have yet to be demonstrated.

Maintenance Therapy: The current recommended adult oral dosage is 150 mg or 10 mL (2 teaspoonfuls equivalent to 150 mg of ranitidine) at bedtime.

Pathological Hypersecretory Conditions (such as Zollinger-Ellison syndrome): The current recommended adult oral dosage is 150 mg or 10 mL (2 teaspoonfuls equivalent to 150 mg of ranitidine) twice a day. In some patients it may be necessary to administer Zantac® 150-mg doses more frequently. Dosages should be adjusted to individual patient needs, and should continue as long as clinically indicated. Dosages up to 6 g per day have been employed in patients with severe disease.

Benign Gastric Ulcer: The current recommended adult oral dosage is 150 mg or 10 mL (2 teaspoonfuls equivalent to 150 mg of ranitidine) twice a day.

GERD: The current recommended adult oral dosage is 150 mg or 10 mL (2 teaspoonfuls equivalent to 150 mg of ranitidine) twice a day.

Dosage Adjustment for Patients with Impaired Renal Function: On the basis of experience with a group of subjects with severely impaired renal function treated with Zantac, the recommended dosage in patients with a creatinine clearance less than 50 mL/min is 150 mg or 10 mL (2 teaspoonfuls equivalent to 150 mg of ranitidine) every 24 hours. Should the patient's condition require, the frequency of dosing may be increased to every 12 hours or even further with caution. Hemodialysis reduces the level of circulating ranitidine. Ideally, the dosing schedule should be adjusted so that the timing of a scheduled dose coincides with the end of hemodialysis.

HOW SUPPLIED: Zantac® 300 Tablets (ranitidine hydrochloride equivalent to 300 mg of ranitidine) are yellow, capsule-shaped tablets embossed with "ZANTAC 300" on one side and "Glaxo" on the other. They are available in bottles of 30 (NDC 0173-0393-40) tablets and unit dose packs of 100 (NDC 0173-0393-47) tablets.

Zantac® 150 Tablets (ranitidine hydrochloride equivalent to 150 mg of ranitidine) are white tablets embossed with "ZANTAC 150" on one side and "Glaxo" on the other. They are available in bottles of 60 (NDC 0173-0344-42) and 100 (NDC 0173-0344-09) tablets and unit dose packs of 100 (NDC 0173-0344-47) tablets.

Store between 15° and 30°C (59° and 86°F) in a dry place. Protect from light. Replace cap securely after each opening.

Zantac® Syrup, a clear, peppermint-flavored liquid, contains 16.8 mg of ranitidine hydrochloride equivalent to 15 mg of ranitidine per 1 mL in bottles of 16 fluid ounces (one pint) (NDC 0173-0383-54).

Store between 4° and 25°C (39° and 77°F). Dispense in tight, light-resistant containers as defined in the USP/NF.

September 1991

Glaxo Pharmaceuticals™
DIVISION OF GLAXO INC.
Research Triangle Park, NC 27709

Zantac® Syrup:
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Newswatch

SCRUTINY OF HOSPITAL-PHYSICIAN FINANCIAL ARRANGEMENTS...

At an April 1, 1992, conference, the federal Department of Health and Human Services and the Internal Revenue Service announced that possible Medicare fraud and abuse and tax-exempt transaction investigations will increase dramatically during the next several years and will focus on hospital-physician joint ventures.

MEDICARE RBRVS...

The American Medical Association (AMA) submitted a letter to the Health Care Financing Administration (HCFA) on March 24, 1992, at the close of the 120-day comment period, regarding the Medicare fee schedule adopted in November 1991. The AMA stated that inaccuracies in the schedule may have a devastating impact on physicians if they are not corrected. HCFA is planning to publish a list of revisions in September 1992, to be effective January 1993.

In its annual report to Congress, the Physician Payment Review Commission recommended legislative changes in the global surgery policy, the technical components expense factors, the evaluation and management code format, the electrocardiogram policy, and the repeal of payment reductions for new physicians. The Commission asked Congress to amend the limiting charge statute to clarify that beneficiaries are not liable for excessive charges and that physicians are required to make refunds for exceeding the limiting charges.

STATE HEALTH PLAN...

The controversial State Health Plan has been stalled due to MSNJ-led opposition. As a result of numerous complaints against "top down planning" being used to develop the State Health Plan, the Health Care Administration Board voted to allow an extended comment period before acting on the proposal. Meanwhile, the Legislature is considering bills to delay the operative date of the Plan and to make it "advisory" rather than mandatory. Simultaneously, the Senate Health Committee has had a series of hearings to discuss extensive revisions to the Health Care Cost Reduction Act of 1991.

May 1992

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NEW JERSEY MEDICINE

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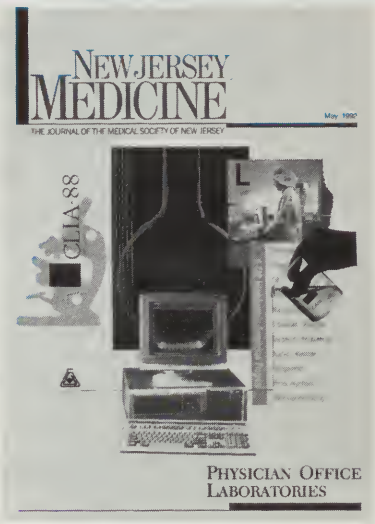
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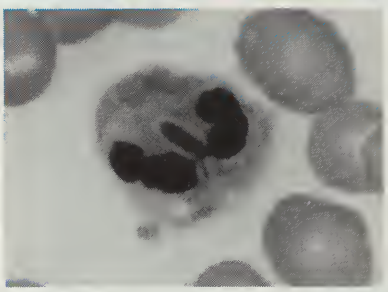
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MSNJ NEWSLETTER

HONORABLE MENTION FOR NEW JERSEY MEDICINE

NEW JERSEY MEDICINE won an honorable mention, for third place, in the 17th Annual Medical Journalism Competition sponsored by Sandoz Pharmaceuticals. A framed certificate was given to the editorial staff of *NEW JERSEY MEDICINE* by Craig Burrell, MD, vice-president of Sandoz Pharmaceuticals. He noted, "Readers of medical and pharmaceutical publications receive stacks of journals, magazines, and other mail. It is a tribute to the editorial staffs of these local publications that they are so avidly read by many other readers who rank them with major national media. We are proud that our workshops and other Sandoz projects have helped to improve the design and editorial features of many of these publications, including dozens of nonwinners." *NEW JERSEY MEDICINE* has been the recipient of various awards over the past 11 years, including a first prize in the Sandoz Competition in 1989, and a Special Award for second place in 1990.

HOSPITAL OUTPATIENT LAB SERVICES

The Division of Medical Assistance and Health Services has submitted a proposal concerning reimbursement for hospital outpatient laboratory services that will appear in a future issue of *New Jersey Register.*

The proposal applies to acute care general hospitals, special hospitals A and B including rehabilitation hospitals, and private psychiatric hospitals.

The Division is repealing the reimbursement methodology based on the Medicare A status file.

The Division intends to base reimbursement for hospital outpatient laboratory services on *Procedure Code Manual for Clinical Laboratories* at N.J.A.C. 10:61-3.

There still are some laboratory procedure codes subject to the cost-to-charge ratio and listed as exceptions to the general reimbursement policy.

Hospital outpatient laboratories billing the New Jersey Medicaid program will be required to enter the Health Care Financing Administration Common Procedure Coding System on the claim form.

Full text of the proposal will appear in *New Jersey Register.*

CONFERENCE ON DEVELOPMENTAL DISABILITIES

The Academy of Medicine of New Jersey (AMNJ), Mainstreaming Medical Care (a program of the Association for Retarded Citizens of New Jersey), and Rutgers University School of Social Work, are sponsoring the Third Annual Conference on Medical Care for People with Developmental Disabilities. The conference will be held on May 15, 1992, from 9:00 A.M. to 3:30 P.M. at Rutgers University, New Brunswick. The morning plenary session will feature Paul Armstrong, Esquire, and Herbert Hinkle, Esquire, who will address the topic, "Advance Directives and Medical Consent for People with Developmental Disabilities." The registration fee is $10 for registrants who bring lunch and $20 for those who have lunch at the conference. For more information or to request a brochure, please call Beverly Roberts, Director, Mainstreaming Medical Care, 1/908/246-2525.

AMNJ designates this continuing medical education activity for 5 credit hours in category 2 of the Physician's Recognition Award (PRA) of the American Medical Association (AMA). The revised AMA guidelines for earning PRA now require 20 hours of category 2 credit per year as well as 20 hours of category 1 credit, and 10 hours of category 1 or 2. This program also has been approved for 5 prescribed hours by the American Academy of Family Physicians.

MEDICAL BOOK COLLECTING

Bibliophilia and medical history will be the theme of a program presented on May 19, 1992, by the Medical History Society of New Jersey at its Annual Meeting to be held at the Nassau Club in Princeton. W. Bruce Fye, MD, has been selected to deliver the Annual Morris H. Saffron Lecture. His address is entitled, "Medical Book Collecting and Scholarship: Past, Present, and Future."

Papers also will be presented by Francis P. Chinard, MD, "Bibliophilia or Bibliomania? A Case Study"; Estelle Brodman, PhD, "Enough Responsibilities for All: Collectors, Book Dealers, and Librarians"; and Thomas A. Horrocks, MA, MS, MLS, "A Quiet Lover of Books: Dr. Samuel Lewis of Philadelphia and His Library." Two informal talks will be given by Ira M. Rutkow, MD, DrPH, "Experiences of a Book Collector and Surgical Historian," and Richard P. Wedeen, MD, "A Historic Find: Charcot's Gift to Lancereaux."

For registration and information, please contact Lisa Swartek, Medical History Society of New Jersey, Two Princess Road, Lawrenceville, NJ 08648, 1/609/896-1717.

ADVANCE DIRECTIVES FORM AVAILABLE FROM COMMISSION

A booklet containing forms for people to use in developing advance directives is available from the State Bioethics Commission, CN-061, Trenton, NJ 08625. Enclose a self-addressed 9″ x 12″ envelope with $1 postage. The forms include: instructions on when to use life-sustaining treatments; appointment of a health care proxy to make decisions about life-sustaining treatment; and combined form with instructions and appointment. Although other, simpler forms also are available, these forms, accompanied by explanations, were produced by the Commission, which developed the state law that took effect January 7, 1992.

POISON INFORMATION & EDUCATION

Information about adverse drug reactions, drug interactions, dosages for renal dialysis patients, drug cautions for nursing mothers, and unapproved drug uses, as well as drug identification, may be obtained 24 hours a day, seven days a week, from the New Jersey Poison Information and Education System (NJPIES). The System uses on-line computer and abstracting services to complement its own reference library. Serving as medical director of NJPIES is Steven M. Marcus, MD, of Essex County. Call 1/800/962-1253.

HEALTH CARE REFORM

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READERS' SURVEY

Watch for our readers' survey next month. The survey will seek to identify readers' greatest areas of relevant interest. We also want to assess how well this commentary meets your needs.

STATE REGULATION

Reversal in Massachusetts. Developments in other states can help instruct health policy decision makers in New Jersey, currently wrestling with fundamental questions involving the proposed State Health Plan, uncompensated care financing, and hospital reimbursement.

Massachusetts, one of three other states that, like New Jersey, has consistently regulated hospital reimbursement and other aspects of health care, recently withdrew from the regulatory arena. In a *Journal of American Health Policy* article entitled, "Mass Retreat," Massachusetts state representative John E. McDonough comments on the factors that led the Bay State to abandon the model promoted by Mr. McDonough and prescribed by the Dukakis administration during the 1980s.

Mr. McDonough asserts that in 1988-1989 expenditures rose under incentives for hospitals to increase the volume of admissions. Rising expenditures weakened support for the regulatory approach.

At the same time, diverse factors combined to make the legislative climate favorable to deregulation. These factors included: the state's thriving HMO industry's interest in preserving discounted rates from hospitals; Blue Cross's desire to be able to negotiate its own discounts; the hospital industry's ultimate support for deregulation; and the lack of enthusiasm for regulation among business, labor, and consumers.

Mr. McDonough notes that the Dukakis administration's "key interest was to delicense empty hospital beds and to close as many hospitals as possible on the theory that capacity shrinkage would reduce costs. The evidence suggests that this theory was wrong." He concludes, "Poorly crafted regulation bears the seeds of its own destruction."

Costs soar in California. The deregulatory model, however, also was criticized in the *Journal of American Health Policy* in an article entitled, "Competing to Death: California's High-Risk System." A team of analysts from Boston University blamed procompetitive policies for increasing per capita health expenditures in California to the second highest level in the country while creating huge numbers of uninsured. (Californians without health insurance now include more than 2 percent of the total United States population.)

ANTITRUST ENFORCEMENT

The legal risks of physicians' joint ventures are expanding at the speed of law. "Self-referrals" by physicians to ancillary services in which they have an economic interest are under assault by the federal Health Care Financing Administration under new federal Clinical Laboratory Improvement Act restrictions, by the inspector general of the United States Department of Health and Human Services under Medicare fraud-and-abuse rules, by the State Board of Medical Examiners (though probably ineffectively) under new business practice regulations, by the State Department of Health under State Health Plan strategies, by the American Medical Association under new ethics guidelines, and by the Federal Trade Commission (FTC).

In a recent speech to the National Health Lawyers Association, the director of FTC's Bureau of Competition discussed antitrust enforcement of medical joint ventures. In the *Cleveland Clinic* cases in Florida, the FTC supported a new and innovative competitor that was offering health care to consumers at a fixed price based on diagnosis. The Cleveland Clinic faced alleged threats by the established medical community against hospitals doing business with the clinic. Physicians also allegedly agreed not to refer patients to the clinic. In the *Southbank* case, the FTC went after a "sham independent practice association (IPA)" that allegedly existed mainly to negotiate as a bloc with third-party payers and appeared to offer no prospect of holding down costs or increasing quality.

After discussing these cases, Kevin J. Arquit noted that his Bureau of Competition, the FTC Bureau of Economics, and several FTC regional offices are investigating diverse joint ventures that, in his view, involve the "channeling" of patients to a provider's own ancillary service. Mr. Arquit contended that profitable channeling violates

multiple provisions and theories of antitrust laws: Section 2 of the Sherman Act, when monopoly power—even substantially less than a total monopoly—is attained by exclusionary methods rather than by successful competition; Section 7 of the Clayton Act, when joint ventures reduce competition substantially or "tend to create a monopoly"; Section 1 of the Sherman Act, when joint venturers agree to refer patients only to their own facility (a "cavalier" approach, observes Mr. Arquit, "considering that openly entering such an agreement would be tantamount to painting a target on one's back for the inspector general's anti-kickback enforcers"); Section 2 of the Sherman Act, again, when hospitals control their discharge planning programs to steer patients toward their own service or vendor without adequate justification; per se price fixing, when physicians who are joint venturers also agree to charge uniform fees for services not provided through the joint venture; and tying-in agreements, when a physician provides care only to patients who agree to use a particular ancillary service.

Mr. Arquit declared that antitrust action is needed to curb escalating health care costs. In the current enforcement climate, physicians are well advised to be wary of participating in any joint venture, however well-intended.

MALPRACTICE AND OTHER CASES

Federal tort claims. New Supreme Court Justice Clarence Thomas has written his first majority opinion, and it involved medical malpractice. In *Molzof v. United States*, 112 S.Ct. 711, decided January 14, 1992, the nation's high court permitted a plaintiff to obtain damages for future medical expenses and loss of enjoyment of life for injuries sustained in a Veterans Administration (VA) hospital. The Federal Tort Claims Act bars "punitive damages" from the government, which argued in this case that an award for future medical expenses would be punitive in light of the patient's right to lifetime care in VA facilities, and that an award for loss of enjoyment of life would be punitive in light of the fact that the patient became comatose within minutes of being deprived of oxygen when a ventilator was negligently disconnected.

Writing for a unanimous Court, Justice Thomas applied a narrow definition to punitive damages, which he labeled "a legal term of art that has a widely accepted common law meaning." He added that the government's interpretation "would be difficult and impractical to apply."

Wrongful life. New Jersey's Supreme Court will decide whether to hold a hospital liable for a failure to advise a seriously ill pregnant woman of abortion alternatives. The case is being brought on behalf of a 20-year-old, severely brain-damaged woman who was born at a Catholic hospital.

In 1984, the court ruled that both mother and child may recover the cost of medical expenses associated with a failure to warn the pregnant woman of likely consequences of birth. The new case would extend wrongful-birth liability to situations not covered by *Roe v. Wade*, the famously controversial 1973 decision establishing the right to abortion under the U.S. Constitution. *Roe v. Wade* was decided after the birth of the New Jersey plaintiff, and is expected to be overruled this year.

MALPRACTICE POLICY TRENDS

Disturbing trends. A 59 percent increase in the average amount of jury verdicts was found in 1990 by the Jury Verdict Research Service, according to *Medical Liability Monitor*. In a survey of 40 medical malpractice insurance companies, the *Monitor* ascertained that claims frequency rose 9 percent, and claims severity rose 10 percent, in 1991. "The good times," reported the monthly reporter, "may be winding down."

The Maine question. The state of Maine has initiated a five-year demonstration program, under legislation backed by the Maine Medical Association, limiting the malpractice liability of physicians who adhere to prescribed practice protocols. Ninety percent of eligible physicians—who include obstetrician/gynecologists, anesthesiologists, radiologists, and emergency physicians—have signed up to participate. The issue of whether practice parameters protect physicians and cut down on defensive medicine may never be decided, though, as plaintiffs are expected to challenge the law's constitutionality.

Cap on pain and suffering. Maryland's Court of Appeals has sustained the state's $350,000 cap on noneconomic damages in a 7 to 2 decision. The scorecard of recent decisions on the constitutionality of caps reveals that caps have been overturned in Alabama and Ohio and upheld, by a federal appeals court, in Louisiana. The main argument against the caps is that they restrict plaintiffs' recovery rights without achieving any benefit to society, because they have not been shown to lead to any reductions in malpractice premiums.

MALPRACTICE TIPS

Clinical guidelines on pain. The Agency for Health Care Policy and Research, part of the

U.S. Department of Health and Human Services, has issued packaged guidelines on pain management. For example, the guidelines on pain management in children advise clinicians to "consider writing orders so the child or parent may refuse an analgesic if the child is asleep or not in pain," and to "use oral administration as soon as the patient can tolerate oral intake." The guidelines also eschew as-needed (prn) orders for children. Agents, dosages, and schedules also are discussed. Included in the materials is a short patient's guide.

Proper recordkeeping. "Consider these office chart documentation recommendations by malpractice claims managers, attorneys, and loss prevention experts," advises *Loss Minimizer,* a monthly report on medical malpractice risk management: Update information on allergies, medications, and other physicians. When several physicians in a practice see a patient, maintain a "problem list" that identifies medical conditions, dates, and outcomes. Enhance notes with drawings and diagrams. Initial reports from laboratories and consultants. Also initial all chart entries and telephone messages involving conversations between the patient and office staff. Make progress notes sufficiently detailed. Complement informed consents with a note stating that the patient was advised of the benefits, risks, and alternatives associated with the procedure, and that the patient's questions were answered and that the patient appeared to understand the risks. Common risks should be specifically listed. Document a patient's noncompliance with recommended actions, including broken appointments, and conclude progress notes with a statement of when the patient was advised to return. Also document patient education. Review records from time to time as a quality-assurance strategy.

Contraceptives and smoking. Despite ubiquitous smoking warning labels on contraceptives, the Pennsylvania Medical Society Liability Insurance Company's Risk Management Committee reports a widespread dearth of smoking histories on the charts of patients taking oral contraceptives. The committee advises documenting both the smoking history and the physician's advice to quit smoking for specific reasons.

Health law handbook. To order the 1991 Health Law Handbook edited by Alice Gosfield and published by Clark Boardman Callaghan, call 1/800/221-9428 or send a FAX to 1/708/948-9340. The price is $65.

NATIONAL HEALTH REFORM

Voters' attitudes. Congresswoman Marge Roukema, a Republican from Ridgewood, discerned widespread dissatisfaction with health care costs, but satisfaction with quality of care, in a recent survey of constituents. "Make no mistake about it," the congresswoman stated in a letter to selected citizens in her relatively affluent district, "there is a tidal wave of public opinion driving this nation toward a restructuring of the health care system."

Legal business is booming. Business is booming among health lawyers, reported a Washington antitrust attorney interviewed by the *New Jersey Law Journal.* An article in the journal noted a proliferation of enforcement efforts on the part of federal agencies seeking to restrain health care costs.

National health expenditures. Eight hundred seventeen billion dollars, amounting to 14 percent of the gross national product, is the magic number for projected 1992 health expenditures in the United States, according to the Commerce Department. Twenty-one percent of these expenditures go for physician services, which, like hospital services, climbed 11 percent in 1992.

The *Journal of American Health Policy* reported the Commerce Department figures along with data showing that the United States consumes 47.5 percent of the world's health care technology products, and that 36 million Americans did not have health insurance in 1990.

MALPRACTICE VERDICTS

Judgment against orthopedists. An orthopedic surgeon involved in the bilateral insertion of Knowles pins to correct growth plate difficulties in a 12-year-old, and also involved in the patient's postoperative monitoring, was found 75 percent liable for a $280,000 verdict by a New Jersey jury. Apparently the jury was persuaded that the pins were improperly placed due to a failure to take lateral x-rays and that they remained in the patient for nine months, causing arthritis and the need for eventual hip replacement surgery. The surgeon's partner, also an orthopedist who was present during the surgery, was found 25 percent liable.

An expert witness for the plaintiff testified that intraoperative lateral x-rays are required in order to avoid placing the pins in an excessively deep area, and that postoperative lateral x-rays are required to ascertain whether the pins were properly placed. The plaintiff argued that the pins, which were supposed to be placed in the middle of the femoral head, were abrading against the acetabulum.

One month after surgery, anterior-posterior views revealed a protrusion of approximately one-eighth inch. Because there was no complaint of pain, the surgeon decided against additional surgery.

The expert claimed that surgery should have been performed at that point to pull the pins back from their base.

The defense claimed that arthritis pre-existed and could not have been caused by the protrusion of the pins, which, the defendant maintained, were not protruding beyond cartilage. But, the plaintiff insisted that preoperative x-rays demonstrated that arthritis did not pre-exist.

Although not in pain, the plaintiff is constrained from participating in sports, including baseball, football, hiking, and tennis. He currently is an engineering student in college. The jury awarded $250,000 to him and $30,000 to his parents, but the court reduced the parents' award to $5,300 for medical expenses.

Pediatric nurse wins damages. A pediatric nurse claimed she sustained a probable herniated lumbar disc and fractures to two lumbar transverse processes when her foot fell into a three-inch wide gap at the end of an ambulance dock at a hospital. At the time she was loading an Isolette™, weighing between 200 and 300 pounds and containing a critically ill baby, into a waiting ambulance. In a 1989 trial, a jury found the New Jersey hospital 85 percent negligent and the nurse 15 percent comparatively negligent. In a recent trial for damages only, a jury computed damages at $908,000.

The nurse, who was employed by the hospital to which the patient was being transferred, produced evidence that she never will be able to lift loads greater than ten pounds and consequently no longer can practice her profession. The bulk of the damages consisted of lost earnings.

In dispute at the trial were the alleged fractures and herniated disc. The defendant asserted the alleged herniation in fact was a degenerative anomaly unrelated to the incident. An orthopedist's discharge note had characterized the injuries as soft tissue in nature, but the orthopedist testified on the plaintiff's behalf that this characterization was made only because a diagnosis was required as a formality and test results had not yet confirmed her strong suspicion of disc pathology. ☐ James E. George, MD, JD; and Neil E. Weisfeld, JD, MsHyg

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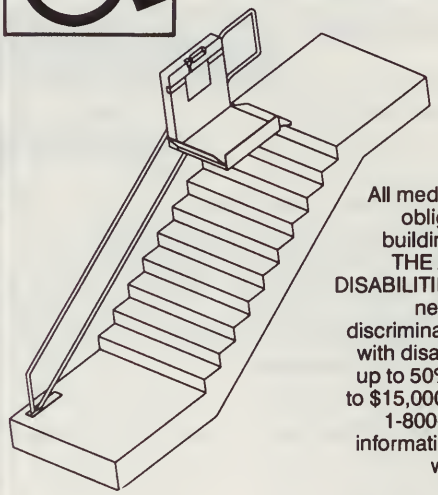
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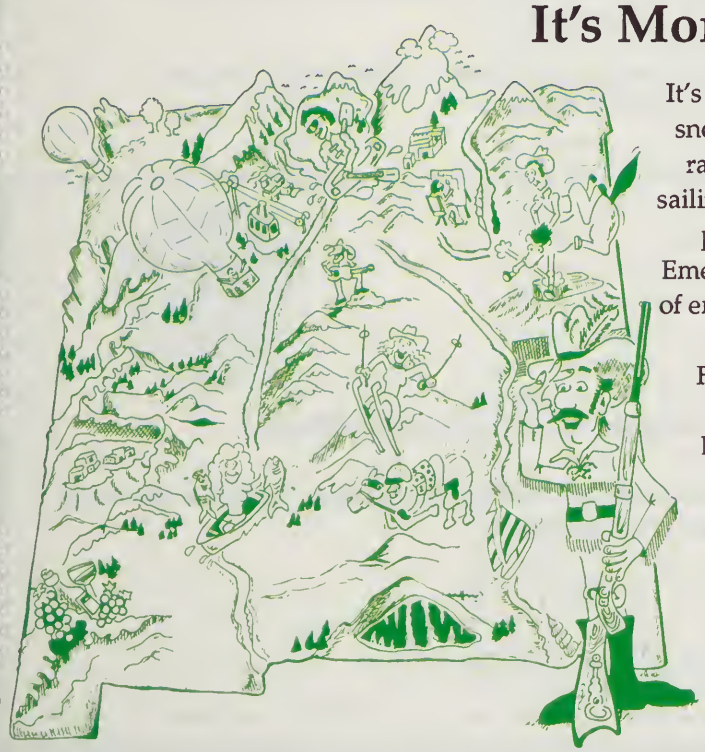
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BOOK REVIEWS

GASTROENTEROLOGY

M.C. Allison. St. Louis, MO, Mosby Year Book, 1991. This is an excellent collection of photographs, radiographs, endoscopic pictures, and histopathologic slides illustrating various diseases of the gastrointestinal tract and liver. The diagnostic picture test format is an enjoyable way to review or to learn about these disorders. Many common and uncommon digestive problems are included. I believe this is an effective teaching tool and can be an important supplement to standard texts.

Residents and fellows especially will benefit from this format, but clinicians involved in the practice of gastroenterology will profit from this self-assessment.

There are 183 photographs followed by questions. Although most pictures are rather basic, some are subtle and quite challenging. I enjoyed answering the questions and plan to use the "test" to teach residents and students. ☐ Joel D. Levinson, MD

HAZARDOUS WASTE AND HUMAN HEALTH

British Medical Association. New York, NY, Oxford University Press, 1991. This book is a composite of pertinent information regarding hazardous waste. It gives historic background concerning recognition of the problem and the attempts to deal with hazardous waste. Control of waste, disposal methods, and the health consequences in animals and humans are considered as well as how these problems might be confronted in the future.

Although a substantial part of the book deals specifically with English problems, much of the material pertains to hazardous wastes in other countries including the United States. There is an excellent account of the Love Canal events. Pollution, ocean bathing, and the United States' and English mechanisms of dealing with the toxic waste problem also highlight this book. The English authors address the epidemiological approach with careful scientific case study data to arrive at conclusions.

The authors emphasize the need for interaction between the medical community and the environmental branch of government. As they compare the efforts of various countries in dealing with the hazardous waste issue, it appears that the United States is more advanced in dealing with the problem than European countries. The authors stress the need for a European version of our Department of Environmental Protection to deal more effectively with problems in Europe. The authors also stress the joint responsibility of the medical community and government agencies to inform the public in an objective, noninflammatory manner and to solicite public support and participation.

It is to their credit that the authors are specific in their observations. The book is nontechnical and may be recommended as good reading for all persons interested in the subject. ☐ Stanley R. Lane, MD

PROGRESS IN CARDIOLOGY

Douglas P. Zipes, MD; Derek J. Rowlands, MD. Philadelphia, PA, Lea & Febiger, 1991. This well-written book is the second in a

series on congestive heart failure. It covers treatment, pathophysiology of ventricular dysfunction, and the role of surgery in the management of congestive heart failure. The text also covers new and interesting topics of personality types, sleep disorders, and different hormonal states, and their relation to coronary artery disease.

The authors present an overview of new technologies in cardiology, covering fiberoptic angioscopy of cardiac chambers and valves, antibodies in the treatment of cardiovascular diseases, and coronary sinus retroperfusion.

This book is excellent for internists and cardiologists interested in keeping abreast of recent advances in cardiology. The authors discuss topics adequately and provide good references. I found it easy to read and clinically oriented. ☐ Sharan Mahal, MD

MEDICAL PROFESSIONAL LIABILITY INSURANCE

American Medical Association. Chicago, IL, 1992. The front cover of this book, published by the American Medical Association, states: *"The Guide to Medical Professional Liability Insurance* is the first complete and unbiased source of information about one of the most critical and costly, but least understood, aspects of medical practice. *The Guide* identifies questions—and provides answers—that every physician should know to make an informed and confident decision about professional liability insurance." This quotation accurately describes this book, which is extremely comprehensive and yet easy to read. It has plenty of space between the lines and does not crowd the pages with print copy. All of this helps to make the book user friendly.

The authors carefully describe the differences between occurrence form insurance coverage and claims-made coverage. It aptly describes "noses" and "tails." It also explains newer concepts such as self-insurance, risk retention groups (RRGs), and risk purchased groups (RPGs).

The Guide contains information on the role of the defense attorney retained by the insurance company to defend the insured physician and points to a number of ways in which the differing interests of the insurer and the insured physician can raise conflicts of interest for the defense attorney. Nonetheless, the book clearly states that the physician, not the insurer, is the attorney's client.

The authors also detail the problem of insurance company reservation of rights or exclusions of coverage. There are many other important topics covered in the book, including information about the National Practitioner Data Bank and its statutory reporting requirements.

Finally, the book contains information on what a physician should do when a claim or a potential claim occurs, a listing of the leading medical malpractice insurance companies by state, and the addresses and telephone numbers of state insurance departments. The book closes with an extensive glossary of terms and an index.

All in all, this excellent book is a true value and is highly recommended for every physician's personal library. ☐ James E. George, MD, JD

BOOK REVIEWS

Book reviews are welcomed by the editor-in-chief. Reviews will be peer reviewed and are subject to editing. Publication will be on a space available basis. Address letters and reviews to Howard D. Slobodien, MD, Editor-in-Chief, *NEW JERSEY MEDICINE,* Two Princess Road, Lawrenceville, NJ 08648.

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LETTERS AND VIEWPOINTS

PROSTATE CANCER

This letter is written on behalf of the Urology Society of New Jersey in response to the views expressed by Dr. Zufall in the October 1991 issue of *NEW JERSEY MEDICINE* (88:737, 1991). We would like to point out that the views expressed by Dr. Zufall are his personal opinions and not necessarily those expressed or practiced by the urological community.

While Dr. Zufall does accurately reflect the history and various treatments for the disease, we are not sure that an accurate assessment message has been given to the medical community in what appears to be a semi-official manner, by one who we believe is in the minority of urologists who treat prostate cancer.

Admittedly, prostate cancer does have variable activity and only a 15-year followup is appropriate to measure effects of specific treatment. However, more prognostic measures are available, such as Gleason grading, DNA analysis, and initial testosterone levels, that allow urologists to determine which of those patients with prostate cancer may be at increased risk for developing future problems or are potentially curable, so that appropriate treatment can be instituted.

Perhaps to Dr. Zufall, ignorance is bliss, but should prostate cancer be singled out as a cancer that we can tell men that they do not need treatment for as contrasted to other types of cancer? It is this reasoning that only recently has allowed prostate cancer to obtain the level of concern and attention it deserves. It is only with this new awareness of evaluation and treatment, that progress will be made in the treatment of this deadly disease.

While we all agree that routine screening for prostate cancer neither is necessary nor cost effective, we do feel evaluation of appropriate patients, to determine those with localized disease who are potential candidates for cure, should be the urologist's priority and should not be considered as an "extreme" measure.

We are dedicated to offering patients the best in care. We believe that the standard of care in the urological community mandates patients who have localized cancer of the prostate be offered potentially curable treatment. □
Thomas C. McNamara, MD

RESPONSE: PROSTATE CANCER

In the March 1992 issue of the *Journal of Urology,* Patrick Walsh, who knows as much about prostatic cancer as anyone, stated, "It is a fact that no study has demonstrated that an early diagnosis of prostate cancer increases survival." He goes on to state, "It is reasonable to assume that if a proper study is ever performed, it is likely that screening studies in prostate cancer will demonstrate improved survival." He further stated, "Aggressive therapy should be concentrated only in men who have a projected life span longer than ten years."[1]

A man with apparently localized disease should have the options explained. We can recommend radical prostatectomy or local radiation because, intuitively, it makes sense to try to get rid of his cancer. And we may be prolonging his life. But we must, in all honesty, tell him that, as of what we know now, there is no convincing evidence that we will, indeed, prolong his life. And that if his life expectancy is under ten years, we are surely not going to prolong it.

So, until the proper study for which we all hope and in which we probably should be participating, I think that conservative therapy is an option that should be offered to patients. As for me, I still want mine left alone. To finish Dr. McNamara's quotation, "Where ignorance is bliss, 'tis folly to be wise." □ Robert Zufall, MD

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1. Walsh P: Why make an early diagnosis of prostate cancer? *J Urol* 147:853, 1992.

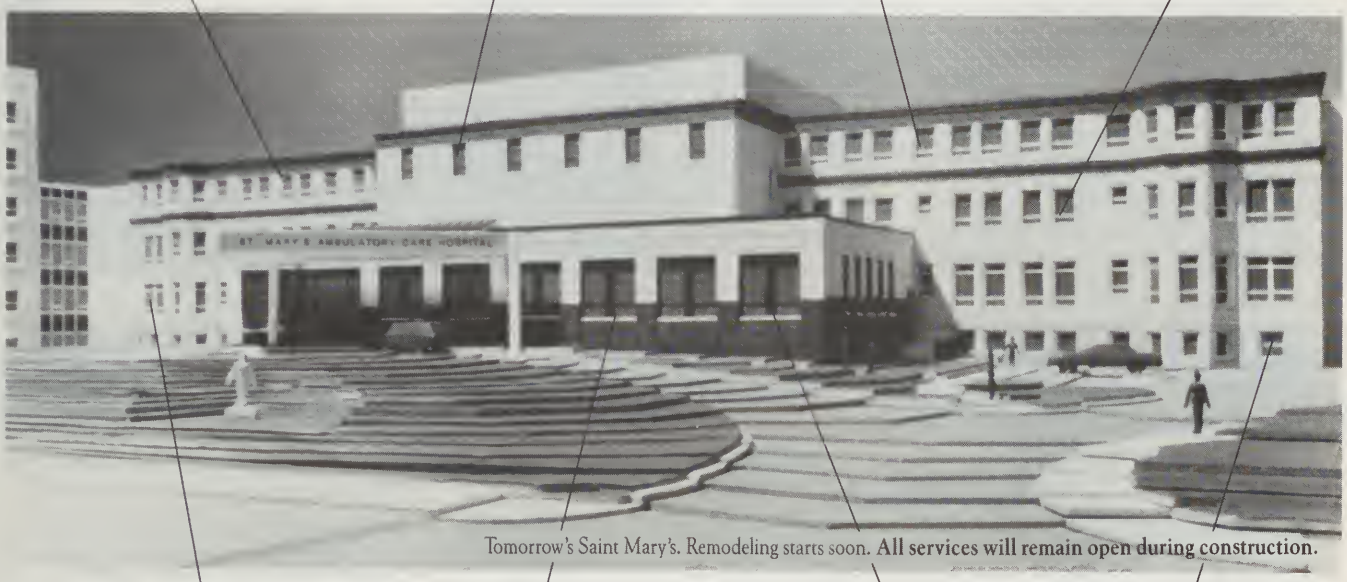
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EDITOR'S DESK

PERSPECTIVES

Politics has become a dirty word and many intellectuals (or pseudointellectuals) feel that participating in the political process is too demeaning for serious consideration.

On a pleasant Tuesday evening in 1991, an obviously fatigued chairman of JEMPAC, weary after a long, pressure-filled day, appeared before our local hospital medical staff. In his official capacity, he solicited the financial support of that staff for statewide elections for a substantial contribution to MEDAC. He gave reasonable arguments in support of that request and invited careful consideration. All he received was abuse. A member of the audience accused the speaker of execrable behavior, of acting immorally in asking the staff to contribute to political action when some of the staff might disapprove or have alternate choices.

We have discoursed previously on political action committees (PACs). We have agreed that many responsible people feel that PACs are an evil to be abolished. But we also have conceded that they are a necessary evil and represent "the only game in town." As such, and because money is the lubricant that oils the political wheels, we either can contribute or concede. To accuse those who are active in PACs of behaving immorally is to climb to the heights of irresponsible behavior. Moreover, it is a cry for anarchy; the classic, "If I can't pitch, I'll take my bat and ball and go home." The dues paid by members of medical staffs and dispensed by the staffs or, usually, by the executive committee, are not distributed with total unanimity. If one objects to a staff donation to the hospital because of a disagreement with hospital policy, can one withhold the dues? If part of staff dues goes toward a party for the employees or toward a staff dinner-dance, where alcoholic beverages may be served, and one is a teetotaler, should that part of the dues be returned? Does the accuser in the audience expect a partial refund of his income taxes any time he disagrees with a government action? As we said, the choice is between democracy and anarchy.



Howard D. Slobodien, MD

Silicone-gel breast implants. The action of Dr. David Kessler of the Food and Drug Administration (FDA) regarding silicone-gel breast implants stirred up a hornet's nest of controversy, as might be expected. Reactions from manufacturers, plastic surgeons, patients (who received implants for both cosmetic and postmastectomy reasons), spokespersons for women's organizations, and ethicists have been swift and predictable. Just as swift and predictable, but perhaps less welcome, have been the responses of some plaintiffs' attorneys. Within days of Dr. Kessler's announcement, we had the expected advertisements in local newspapers: "Silicone implant? If you have one and want to discuss your legal rights with an attorney, call. . . ." We have long realized that ambulance-chasing is a vanishing occupation; it has been replaced by health care monitoring. So the advertisement noted is typical of the new breed of legal practitioners.

Not so typical was the advertisement placed by another legal firm that advised readers that silicone implants caused diseases that were compensable and to call them to obtain said compensation. These attorneys did not care that the jury was still out on the relative benefits and harm of implants. A client is a client is a client, and a large contingent of them can represent an enormous resource should silicone implants be indicted as being too hazardous to health. And if implants were to be cleared of all charges, how much harm would have resulted from that "little white lie" of the attorneys? After all, free consultations were pro-offered.

Finally, the silicone flap had another worrisome effect, not anticipated by this author. As reported by Health Harbinger in *Cancer Monthly Breast Cancer* (March 1992), "Over half of the major health insurance companies surveyed said they are likely to alter their coverage for women with silicone-gel implants, including denying coverage for removal of the devices and possibly halting all coverage to women who have silicone-gel implants, even if the women are happy with their implants." Comments by a Phoenix real estate agent who had

breast reconstruction following a bilateral mastectomy: "Women in my support group can't understand what's happening to them. First, they are diagnosed with cancer. They survive by having their breasts removed. Then they get reconstructed so they can look normal and fully recover. Now that they're cured, the insurance companies are dropping them. What's going on?"

What is going on indeed! Women are in trouble, especially those insured in small groups, as individual subscribers or by employer-funded coverage, where state departments of insurance have little or no jurisdiction. As tradition seems to demand, the little people will be hurt and, pun not intended, women will be left holding the bag. By the time this editorial is in print, it is to be hoped that the FDA will have rendered its verdict—clearly and, most importantly, unequivocally. Our patients deserve no less. □

Every man takes the limits of his own field of vision for the limits of the world.

Schopenhauer, *Parerga and Paralipomena,* 1851

Human history is the sad result of each one looking out for himself.

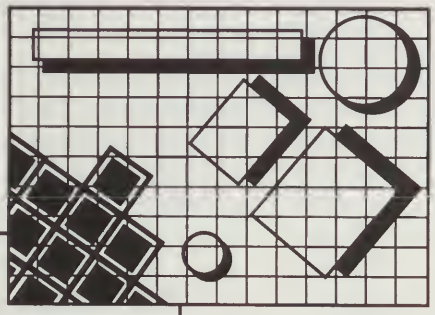
Julio Cortázar, *The Winners,* 1960

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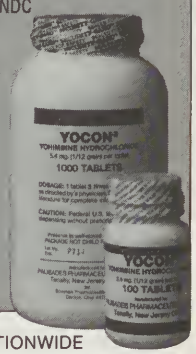
Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

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1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
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4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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PRESIDENT 'S PAGE



FINI

As my term ends as president of the Medical Society of New Jersey (MSNJ), I would like to thank the entire membership for the honor, privilege, and pleasure of having served and represented you.

I am grateful to many of you who have sacrificed your Sunday mornings to regularly attend Board of Trustees' meetings.

I am grateful to all the chairmen and members of the many councils, committees, and task forces who have taken the time and effort to meet several times during the year.

I am grateful to the officers of our Society who have spent extra time at the many executive committee meetings. I have called on each of them during the year to participate, on my behalf, in certain functions that I was unable to attend. Our president-elect, Doctor Bill Ryan, has been asked to pinch hit for me on several occasions; he has done a yeoman's job.

Special thanks to Doctors Doug Costabile, Paul Hirsch, Pam Formica, and Harry Carnes, the four most recent past-presidents. I have continually and confidentially asked for their guidance and wisdom, and they have generously allowed me to benefit from their experience.

This year we established the Council of County Presidents and Executives, who met bimonthly at the Lawrenceville office. At those meetings, county presidents and executives were kept abreast of the ongoing activities; in return, they reported these issues to their membership. We have made strong attempts to keep the membership informed. At the same time, these well attended meetings afforded county leaders an opportunity to express ideas and concerns, and to compare their happenings with those of other counties.

One of the greatest pleasures I had as your president was to visit and enjoy the hospitality of 19 of the 21 county societies. No doubt these sessions always have been more valuable to me for what I learned, rather than to the audience for the update I presented. These visits helped to achieve medical unity and strength. Our successes always are greatest when we act together. Each county has its own geographic location, its own personality, and—what is heartening to me—its own strong dedication and outstanding leadership.

"Together we do it better!" That was the motto that combined MSNJ's efforts with those of our excellent Auxiliary. We cosponsored symposia, petitioned state legislators, and traveled to Washington, DC, to meet with congressional representatives. The Auxiliary is an active and valuable source of energy and together we did do it better!

I can assure you MSNJ is, and will continue to be, concerned about our patients, our profession, and our Society. There is no doubt that our input in the state legislative and regulatory process has grown each year. The extraordinary efforts of our lobbyist, Mr. Clark Martin, have elevated our status to a higher level of legislative sophistication.

To my knowledge, no state medical society does a better job, via political action, than MSNJ. There is no question that we had a strong impact on the outcome of the 1991 state elections, assuring always that elected officials are persons dedicated toward the best possible health care for our patients. Likewise, the New Jersey Delegation to the AMA has had tremendous influence on such issues as AIDS and health care reform. It has been especially rewarding to watch the Delegation metamorphose from the ponderous caterpillar of the 1980s to the free-flying butterfly of the 1990s.

The combined efforts of the Committee on Membership, Committee on Women in Medicine, and Committee on International Medical Graduates, will begin to show results. Collectively, they have contacted hundreds of nonmembers via county society programs, on a one-to-one basis. This makes me confident of new growth in our membership.

I would be remiss if I did not extend my deep personal thanks to our most excellent staff, under the leadership of our experienced executive director, Mr. Vincent A. Maressa, with the able help of Ms. Diana C. Gore. Mr. Neil E. Weisfeld, an unexpected pleasant addition to the staff, also was most helpful. They kept me organized, efficient, and pointed in the right direction. I am told I worked them harder than ever, but they never complained, were always cheerful, and remained true to the task. In return, I gave them my appreciation, love, and loyalty.

Despite the doom, gloom, and perils that exist, MSNJ has remained true to its highest ideals. We have continued to pursue vigorously all those activities that are in the best interest of our patients and our profession. We have fought the good fight! We have kept the faith! More than ever, I believe in MSNJ. We are professionals. We are physicians. We are family. God bless. ☐ Joseph A. Riggs, MD



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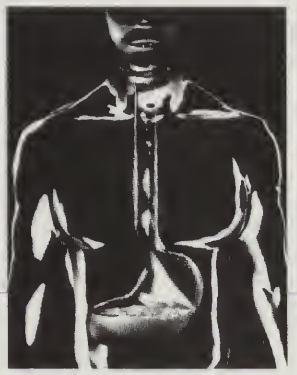
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Indications and Usage: 1. *Active duodenal ulcer*—for up to 8 weeks of treatment at a dosage of 300 mg h.s. or 150 mg b.i.d. Most patients heal within 4 weeks.

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Contraindication: Known hypersensitivity to the drug. Because cross sensitivity in this class of compounds has been observed, H_2-receptor antagonists, including Axid, should not be administered to patients with a history of hypersensitivity to other H_2-receptor antagonists.

Precautions: *General*—1. Symptomatic response to nizatidine therapy does not preclude the presence of gastric malignancy.

2. Dosage should be reduced in patients with moderate to severe renal insufficiency.

3. In patients with normal renal function and uncomplicated hepatic dysfunction, the disposition of nizatidine is similar to that in normal subjects.

Laboratory Tests—False-positive tests for urobilinogen with Multistix® may occur during therapy.

Drug Interactions—No interactions have been observed with theophylline, chlordiazepoxide, lorazepam, lidocaine, phenytoin, and warfarin. Axid does not inhibit the cytochrome P-450 enzyme system; therefore, drug interactions mediated by inhibition of hepatic metabolism are not expected to occur. In patients given very high doses (3,900 mg) of aspirin daily, increased serum salicylate levels were seen when nizatidine, 150 mg b.i.d., was administered concurrently.

Carcinogenesis, Mutagenesis, Impairment of Fertility—A 2-year oral carcinogenicity study in rats with doses as high as 500 mg/kg/day (about 80 times the recommended daily therapeutic dose) showed no evidence of a carcinogenic effect. There was a dose-related increase in the density of enterochromaffin-like (ECL) cells in the gastric oxyntic mucosa. In a 2-year study in mice, there was no evidence of a carcinogenic effect in male mice, although hyperplastic nodules of the liver were increased in the high-dose males as compared with placebo. Female mice given the high dose of Axid (2,000 mg/kg/day, about 330 times the human dose) showed marginally statistically significant increases in hepatic carcinoma and hepatic nodular hyperplasia with no numerical increase seen in any of the other dose groups.The rate of hepatic carcinoma in the high-dose animals was within the historical control limits seen for the strain of mice used. The female mice were given a dose larger than the maximum tolerated dose, as indicated by excessive (30%) weight decrement as compared with concurrent controls and evidence of mild liver injury (transaminase elevations). The occurrence of a marginal finding at high dose only in animals given an excessive and somewhat hepatotoxic dose, with no evidence of a carcinogenic effect in rats, male mice, and female mice (given up to 360 mg/kg/day, about 60 times the human dose), and a negative mutagenicity battery are not considered evidence of a carcinogenic potential for Axid.

Axid was not mutagenic in a battery of tests performed to evaluate its potential genetic toxicity, including bacterial mutation tests, unscheduled DNA synthesis, sister chromatid exchange, mouse lymphoma assay, chromosome aberration tests, and a micronucleus test.

In a 2-generation, perinatal and postnatal fertility study in rats, doses of nizatidine up to 650 mg/kg/day produced no adverse effects on the reproductive performance of parental animals or their progeny.

Pregnancy—Teratogenic Effects—Pregnancy Category C—Oral reproduction studies in rats at doses up to 300 times the human dose and in Dutch Belted rabbits at doses up to 55 times the human dose revealed no evidence of impaired fertility or teratogenic effect; but, at a dose equivalent to 300 times the human dose, treated rabbits had abortions, decreased number of live fetuses, and depressed fetal weights. On intravenous administration to pregnant New Zealand White rabbits, nizatidine at 20 mg/kg produced cardiac enlargement, coarctation of the aortic arch, and cutaneous edema in 1 fetus, and at 50 mg/kg, it produced ventricular anomaly, distended abdomen, spina bifida, hydrocephaly, and enlarged heart in 1 fetus. There are, however, no adequate and well-controlled studies in pregnant women. It is also not known whether nizatidine can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Nizatidine should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers—Studies in lactating women have shown that 0.1% of an oral dose is secreted in human milk in proportion to plasma concentrations. Because of growth depression in pups reared by treated lactating rats, a decision should be made whether to discontinue nursing or the drug, taking into account the importance of the drug to the mother.

Pediatric Use—Safety and effectiveness in children have not been established.

Use in Elderly Patients—Healing rates in elderly patients were similar to those in younger age groups as were the rates of adverse events and laboratory test abnormalities. Age alone may not be an important factor in the disposition of nizatidine. Elderly patients may have reduced renal function.

Adverse Reactions: Worldwide, controlled clinical trials included over 6,000 patients given nizatidine in studies of varying durations. Placebo-controlled trials in the United States and Canada included over 2,600 patients given nizatidine and over 1,700 given placebo. Among the adverse events in these placebo-controlled trials, only anemia (0.2% vs 0%) and urticaria (0.5% vs 0.1%) were significantly more common in the nizatidine group. Of the adverse events that occurred at a frequency of 1% or more, there was no statistically significant difference between Axid and placebo in the incidence of any of these events (see package insert for complete information).

A variety of less common events were also reported; it was not possible to determine whether these were caused by nizatidine.

Hepatic—Hepatocellular injury (elevated liver enzyme tests or alkaline phosphatase) possibly or probably related to nizatidine occurred in some patients. In some cases, there was marked elevation (>500 IU/L) in SGOT or SGPT and, in a single instance, SGPT was >2,000 IU/L. The incidence of elevated liver enzymes overall and elevations of up to 3 times the upper limit of normal, however, did not significantly differ from that in placebo patients. All abnormalities were reversible after discontinuation of Axid. Since market introduction, hepatitis and jaundice have been reported. Rare cases of cholestatic or mixed hepatocellular and cholestatic injury with jaundice have been reported with reversal of the abnormalities after discontinuation of Axid.

Cardiovascular—In clinical pharmacology studies, short episodes of asymptomatic ventricular tachycardia occurred in 2 individuals administered Axid and in 3 untreated subjects.

CNS—Rare cases of reversible mental confusion have been reported.

Endocrine—Clinical pharmacology studies and controlled clinical trials showed no evidence of antiandrogenic activity due to nizatidine. Impotence and decreased libido were reported with similar frequency by patients on nizatidine and those on placebo. Gynecomastia has been reported rarely.

Hematologic—Anemia was reported significantly more frequently in nizatidine than in placebo-treated patients. Fatal thrombocytopenia was reported in a patient treated with nizatidine and another H_2-receptor antagonist. This patient had previously experienced thrombocytopenia while taking other drugs. Rare cases of thrombocytopenic purpura have been reported.

Integumental—Urticaria was reported significantly more frequently in nizatidine- than in placebo-treated patients. Rash and exfoliative dermatitis were also reported.

Hypersensitivity—As with other H_2-receptor antagonists, rare cases of anaphylaxis following nizatidine administration have been reported. Rare episodes of hypersensitivity reactions (eg, bronchospasm, laryngeal edema, rash, and eosinophilia) have been reported.

Other—Hyperuricemia unassociated with gout or nephrolithiasis was reported. Eosinophilia, fever, and nausea related to nizatidine have been reported.

Overdosage: Overdoses of Axid have been reported rarely. If overdosage occurs, activated charcoal, emesis, or lavage should be considered along with clinical monitoring and supportive therapy. The ability of hemodialysis to remove nizatidine from the body has not been conclusively demonstrated; however, due to its large volume of distribution, nizatidine is not expected to be efficiently removed from the body by this method.

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PT Requirements for Physician Office Laboratories

Kathleen Voldish, CLA (ASCP)

The Clinical Laboratory Improvement Amendments of 1988 (CLIA-88) regulations will require physician office laboratories (POLs) to participate in proficiency testing (PT) for all nonwaivered tests performed in private offices. PT will enhance the quality of the testing performed in a POL.



Kathleen Voldish

Proficiency testing (PT) will be a key requirement of the Clinical Laboratory Improvement Amendments of 1988 (CLIA-88) regulations. Laboratory organizations have recommended that physicians performing laboratory testing participate in PT. Presently, less than 10 percent of all physician office laboratories (POLs) are enrolled in such programs. POLs enrolled in PT programs will have a distinct advantage over POLs that have not participated in PT when CLIA-88 regulations are implemented. It is possible that when regulations are implemented, PT companies will not be able to meet the demand, and POLs will be placed on waiting lists for enrollment.

PT is an external quality control that checks the precision and accuracy of laboratory results. Daily internal quality control checks the precision of a test. However, a test may have a high degree of precision but still may not be accurate. If an instrument is not calibrated correctly, it will produce a result, perhaps precise to 3 decimal places—but still an inaccurate result. This leaves the physician in the unenviable position of formulating a proper diagnosis with incorrect test results. Accuracy is how close the result is to the known true value of components being analyzed. PT is a way to verify the accuracy of results generated from the laboratory and provide valuable information for identifying any possible problems. Hospitals and clinical reference laboratories have been required by regulations to participate in PT for decades. Seventeen states already have enacted laws that require all POLs to enroll in PT. The Commission on Office Laboratory Assessment (COLA) started private voluntary accreditation of POLs in 1989 and requires successful participation in PT for all inhouse tests before accreditation is given.

Although CLIA-88 has not specifically stated what PT programs will be accepted, six programs currently are accepted by Medicare, Medicaid, state regulations, and COLA. These programs will seek federal approval and most likely will be accepted by CLIA-88 as well. Some manufacturers provide customer PT programs for their instruments. However, CLIA-88 mandates that all PT providers be nonprofit organizations and must be able to compare results of different instruments and methods, so it is doubtful if manufacturers' programs would be accepted by regulation. Enrollment will be a prerequisite before a provisional certificate is issued by CLIA-88. Physicians should select a program that has all the testing analytes the office staff performs; some programs have larger test combinations and menus than other programs. Selecting the appropriate proficiency program is of paramount importance. A qualified laboratory consultant can recommend a correct, cost-effective program.

After an office PT program has been selected, the physician or staff member should enroll for all tests performed in level I and level II of the CLIA-88 regulations. These are tests exempt from PT; these tests will be listed in the PT or regulatory brochures. The average cost for POL testing

enrollment for one year is $200 to $500. Laboratories performing extensive testing can expect this cost to rise.

How does PT work? Once enrolled in a PT program, a participant will receive a series of "unknown" specimens for testing; this is repeated four times throughout the year. These specimens must be treated and tested in the same way as patient specimens. They must not be sent to a reference laboratory. Do not assume these specimens can be handled the same as quality control specimens. Some specimens will be ready for testing upon arrival, others may need to be reconstituted with distilled water. When the specimen is ready for testing, the participant should perform the correct test. If the result is abnormal, repeat the test, if that is the normal laboratory policy. Write the results on the result form, making sure it is transcribed properly and legibly. The participant must test the specimens and complete the report within the time period specified by the PT company. Result reports that arrive after the specified time limit will not be analyzed. Most companies allow seven to ten working days to analyze the specimens. If copies of the results are to be sent to a regulatory agency or a consultant, specify this to the PT company.

After receiving the results, the PT company compares the participant's results to the mean or true value of the test. All results will be compared to results submitted by other laboratories across the country using the same instruments and methods. Each participant will receive the results of the testing challenge. This data may be difficult to understand. Participants will need to become familiar with terms such as mean, acceptable range, standard deviation (SD), and coefficient of variation (CV). The rule of thumb is that a SD of less than 2 is good (the lower the number the more accurate) and a CV of 5 to 10 percent is good (the smaller the CV, the more accurate the result). A participant should always review results carefully with the laboratory director, and then file the results in an organized notebook. Results should be maintained in the laboratory for three to five years after the instrument no longer is used.

If the participant does not score well or if the participant fails a challenge, it is imperative to determine the reason for the failure. The steps to follow include: reviewing the internal quality control (QC); checking equipment maintenance records to determine if the instrument had been serviced or calibrated, or had routine preventive maintenance performed; and determining the reagent lot number. Most POLs enrolled in PT do well—more than 90 percent receive passing scores (above 80 percent). COLA reports that less than 5 percent of COLA-certified laboratories perform unsatisfactorily. However, all these laboratories are practicing good QC and in many cases, are voluntarily enrolled. This is evidence that the laboratory is conscientious about the tests it performs. Once CLIA-88 is implemented, laboratories will have to pass three consecutive PT challenges (80 percent or better) to receive a certificate of accreditation. Obtaining poor results after being certified by CLIA-88 and failing to correct the problem after two challenges will lead to suspension of Medicare/Medicaid payments for these tests, possible fines, and eventual loss of CLIA certification.

CONCLUSION

It is advisable to enroll in PT before the results are monitored by regulators. POLs participating in PT will have a definite advantage over nonenrolled laboratories when regulations are implemented. Regardless of regulation, PT will enhance the quality of the testing performed in a POL. ■

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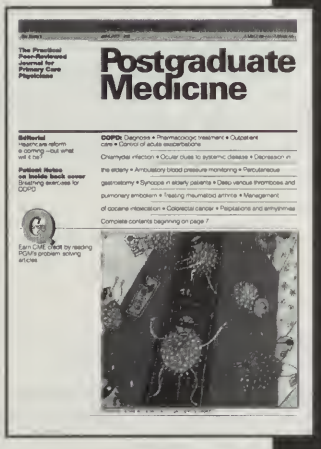
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Ms. Voldish is a registered technologist, laboratory manager, and POL consultant. This paper was submitted in November 1991 and accepted in December 1991. Address reprint requests to Ms. Voldish, POL Consultants, 1150 Concord Drive, Haddonfield, NJ 08033.

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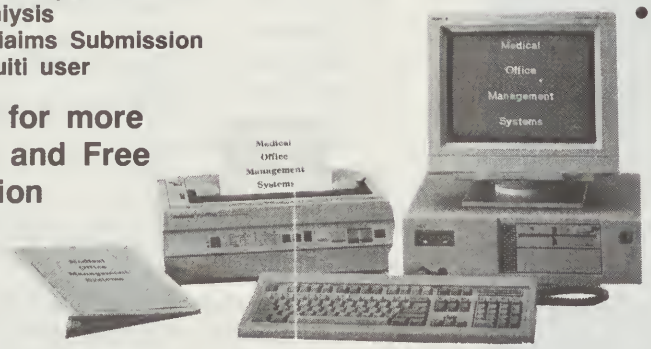
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Personnel Recordkeeping Requirements for CLIA-88

Kathleen Voldish, CLA (ASCP)

Documented personnel files will be a requirement of the Clinical Laboratory Improvement Amendments of 1988 (CLIA-88) regulations. This documentation will help reduce laboratory errors and liability by clearly and completely defining the employee's duties and responsibilities.

In a physician office laboratory (POL) setting, it is common to find everyone from the receptionist to the physician performing tests. According to the doctrine of "respondant superior," a physician is fully responsible and liable for the testing performed in his office laboratory—even if the testing is performed by an employee—as long as the employee is working within his scope of duties. In a case where an employee performs a test that he was not instructed to perform, the liability then would shift to the employee. The Clinical Laboratory Improvement Amendments of 1988 (CLIA-88) regulations specify personnel standards and qualifications for various levels of difficulty of laboratory testing. For these regulatory and legal reasons, physicians should make certain that personnel files for any employee performing in-house tests are accurate and up to date.

The physician serving as the laboratory director should determine which tests any given employee should perform. The complexity of the test as well as the analytical capabilities and technical background of the employee should be considered when making this decision. Once CLIA-88 regulations are implemented, the personnel standards of the act will specify further who can perform any particular test. Employees presently working in POLs should review personnel files with the physician or office manager to properly document duties. New employees should be evaluated for analytical capabilities.

Personnel files on all employees doing laboratory testing should include a copy of the job application; a copy of the employee's résumé; a copy of any certification, license, or registry number; a copy of any degrees, military laboratory training, or technical school diploma; a copy of continuing education credits relevant to laboratory testing; documentation of any "on-the-job" training; "right to know" or OSHA safety training; HBV vaccine form; detailed job description; and yearly evaluation.

Personnel files should be kept in the physician's office; the files should be considered confidential and should be accessible only to the physician and office manager. Once regulations are implemented and POLs are inspected, these files must be available for review by a regulatory inspector.

It is the responsibility of the physician to see that the files are properly documented. If a job application or résumé is available, this is a good way to start. Documentation of training and qualifications can come from numerous sources. If the employee has had a formal technical laboratory background, this training can be verified by diploma, certification, licensing, registration, and/or military training records. If the employee has little or no laboratory background and the manufacturer of the laboratory instrument provided a training program, the training "check sheet" or training certificate should be retained. If the employee has had only on-the-job training provided by another employee or the physician, this needs to be documented. The amount of time the employee spent in training under the supervision of another employee should be stated as well as when the employee was considered adept at the test and considered trained. On-the-job training should be done in a professional and unrushed manner. Whenever possible, equipment manufacturers should train new employees on laboratory equipment.

A job description must define all the duties an employee is expected to perform. This description should be reviewed, under-

stood, and agreed upon by the employee. The following three areas should be included in this description:

1. Administrative duties. Keeping current and accurate quality assurance records such as requisition, test results, and reagent and maintenance logs; writing or updating a laboratory procedure manual; taking inventory and ordering laboratory supplies; maintaining material safety data sheets (MSDS) for OSHA safety manual; maintaining regulated hazardous waste records; and filling out forms for regulation.

2. Testing duties. Performing tests; performing quality control and recording results; performing proficiency testing and reviewing results with the laboratory director; preparing specimens and logging tests to be sent to a reference laboratory; assuring that all test results are reviewed by the physician and abnormal results immediately are brought to the physician's attention; and observing and practicing universal precautions.

3. Maintenance duties. Performing all preventive maintenance on equipment and documenting it; calibrating instruments and performing validation studies after calibration and recording results; troubleshooting any quality control or maintenance problems; calling manufacturer service when professional service is indicated.

It should be stressed to the employee that documentation must never be ignored. This documentation is necessary to validate that testing has been performed properly. These records that can eliminate or minimize any risk or liability that possibly could occur. If records are not kept, it can be assumed that the test in question was not performed properly. Once regulation is implemented, these records will confirm whether the laboratory is meeting the standards.

If a laboratory error does occur, the problem should be documented. Records also should show that reasonable care was taken to correct or rectify the problem. Retest the patient as soon as possible—if possible. Most patients will be understanding, if the problem is explained and handled in a professional manner. Do not try to cover up or ignore a problem.

As of January 1, 1990, OSHA required a documented "Right To Know" training program be given to all employees exposed to body fluids or chemicals in a POL setting. This program protects the physician from liability cases that could occur if an employee is exposed to and contracts an infectious disease or becomes ill due to possible chemical exposure. This law includes nurses, medical assistants, and laboratory personnel. This training can be done in numerous ways. Hospital programs are available to all hospital employees and it may be possible for the physician to arrange with the hospital to allow his employees to attend these programs. Inhouse programs can include videotapes on safety, review of a safety checklist, attendance at seminars offered by technical societies, or the hiring of a laboratory consultant. The physician also must offer each employee an HBV vaccine. In pediatric and obstetrics/gynecology offices, rubella, rubeola, measles, and mumps vaccines may be offered as well. The employee may choose not to take the prescreen test and vaccine, but records must be signed and retained in the employee file. If the employee chooses to receive the vaccine, the physician can administer it.

If the physician routinely gives a yearly employee evaluation, this should be retained in the file. This is the time to review duties and address problems.

CONCLUSION

Properly documented laboratory employee files will be a requirement for implementation of upcoming regulations. Clearly defined duties and limitations will help minimize problems. The cost of one malpractice suit will greatly exceed the cost of a professional lifetime of maintaining proper documentation. ■

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Ms. Voldish is a registered technologist, laboratory manager, and POL consultant. This paper was submitted in November 1991 and accepted in December 1991. Address reprint requests to Ms. Voldish, POL Consultants, 1150 Concord Drive, Haddonfield, NJ 08033.

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Evaluation of Prothrombin Time and Partial Thromboplastin Time

Chitra Lahoti, MD
Anis F. Rangwala, MD

Prothrombin time (PT) and partial thromboplastin time (PTT) tests are commonly ordered for hospitalized patients. A significant reduction in laboratory workload and expense can be achieved if these tests are ordered appropriately. The likelihood that the patient will benefit from these tests is small.

Prothrombin time (PT) and partial thromboplastin time (PTT) tests are ordered routinely by clinicians, either for hospitalized patients or for preoperative investigations. The purpose of our investigation was to study the ordering pattern and clinical indications for PT and PTT tests in the emergency room (ER) and to check the appropriateness of ordering PT and PTT tests using American Medical Association (AMA) guidelines.

Most patients were discharged from the ER and only 18 percent were hospitalized. A few of these patients also underwent operative procedures. Approximately 40 percent of all the patients admitted through the ER had PT and PTT testing. The criteria written by Blue Cross-Blue Shield Association of America, the Medical Necessity Project, and the AMA state that PT and PTT tests are not required in approximately 50 percent of the patients.

This study also followed patients in the hospital to see whether the first set of abnormal PT and PTT tests led to further investigation or changed patient management, and whether patients on anticoagulants were followed by repeated PT and PTT tests.

METHODS

All patients admitted in December 1989 through the ER who had PT and PTT tests ordered on admission were included in this study. Each record was reviewed for presenting complaint; past history including previous surgery and medications; social and family history; physical findings; provisional diagnosis; and tests ordered.

Each patient was followed throughout hospitalization for any new presentations, PT, PTT, and platelet count. The results of fibrinogen, fibrin split products, bleeding time, and other coagulation tests were noted. Use of drugs or blood products to correct coagulation abnormalities also was noted.

Patients were grouped according to criteria (Table 1) endorsed by the American College of Physicians and modified by Dr. Stephen B. Erban.[3] Test instruments included Electra 700 and 800 for PT and PTT tests.

In our study, normal reference values for PT and PTT tests standardized for our laboratory were used, i.e. for PT test, a range of 10 to 13 seconds; for PTT test, a range of 25 to 40 seconds.

The findings were tabulated and statistical comparisons were made. The results were analyzed using the appropriate reference ranges.

RESULTS

General Findings. A total of 3,104 patients were seen in the ER during December 1989. There were 557 patients admitted and 225 of these patients had PT and PTT tests ordered. We studied 195 of these patients. Charts were unavailable for the remaining 30 patients. None of these patients were scheduled for operation. For all these patients, PT and PTT tests were ordered simultaneously at the time of admission, however, only the relevant test was ordered later, when needed.

Table 2 shows the range of diagnoses of representing patients.

Some patients (25 percent) came to the ER with chest pain related to underlying cardiac problems, and eight patients (4 percent) had myocardial infarction.

Other important diagnoses included: bleeding from different sources including hematemesis, hemoptysis, and bleeding (4 percent); thromboembolic disease including CVA and TIA (16 percent of all the patients studied); and hepatobiliary disease on history or physical examination (5.5 percent).

Table 1. *Criteria for use of the PT and PTT tests.*

Preprocedure evaluation
- Evidence of liver disease on physical examination
- History of malabsorption or malnutrition noted
- Clinical history unavailable

Evaluation of abnormal bleeding
- Active bleeding or evidence of abnormal bleeding on physical examination
- History of abnormal, excessive, or spontaneous bleeding

Use of anticoagulants
- Recent or current use of therapeutic heparin or oral anticoagulants

Evaluation of abnormal coagulation
- Suspected or proved thromboembolism
- Suspected or proved disseminated intravascular coagulation

Procedure disruption of normal coagulation
- Shunts, prostatectomy, or cardiopulmonary bypass

Thirty-four patients were on anticoagulants. Six patients were on anticoagulants at the time of admission; only 1 patient complained of bleeding. Twenty-four patients had a past or recent history of malignancy and presented with symptoms and signs related to the neoplasm or its complications. Of these, 1 patient with a history of pancreatic carcinoma developed deep vein thrombosis during hospitalization. Fifteen patients had major operations during the hospitalization; none of these patients had bleeding problems during or after surgery. Five patients were given anticoagulants postoperatively.

PT and PTT test results. Of the 195 PT and PTT tests ordered in the ER, 149 PT tests (76 percent) and 184 PTT tests (94 percent) were normal (Tables 3 and 4). Twenty-nine PT tests (15 percent) and 3 PTT tests (1.5 percent) were abnormal, without proved cause.

Of the 195 patients who had PT and PTT tests ordered in the ER, only 97 patients (49 percent) met the appropriate criteria as shown in Table 2. Table 3 shows the number of patients with the indication for appropriately ordered PT and PTT tests.

Only 30 percent of the patients admitted with cardiac complaints and only 14 percent of the patients admitted with respiratory complaints needed PT and PTT testing at the time of admission. None of the patients who presented with obstetrical problems needed these tests at the time of admission or during the hospital stay.

PT. There were 29 patients with abnormal initial PT test results without a known cause on review. Of the nine tests that were repeated, five tests were normal. Of the remaining 4 patients with an abnormal PT test, 2 patients had a history of chronic renal failure and were on dialysis, but the other 2 patients had no obvious cause. The method of specimen handling and the interval between the collection and delivery may have contributed to abnormal results. None of these 4 patients required any active management. For the remaining 20 patients, the PT tests were not repeated and no further treatment was given.

Only 1 of 17 patients with abnormal PT tests due to drugs or disease (5.9 percent) required treatment. This patient had a history of alcoholic cirrhosis with a portocaval shunt and was admitted for myocardial infarction and gastrointestinal bleeding. The PT value was repeatedly high with normal PTT values. This patient was given blood transfusions and vitamin K, to which he responded. Of the remaining 16 patients with elevated PT value, 5 patients had malignancies and abnormal liver function tests; 3 patients had histories suggestive of malabsorption, and 1 patient had abnormal liver function; 2 patients had AIDS and abnormal liver function; 6 patients were on anticoagulants at the time of presentation, and 1 patient had a history of prolonged bleeding following a razor cut.

PTT. Only one of the three abnormal PTT results without any cause on initial review of the charts was repeated, and this showed a normal result. The PTT test was not repeated for the other two patients. On re-review of their clinical records, no abnormality was noted clinically or in other laboratory investigations including liver function tests. However, one of these patients came with postpartum bleeding after delivering in another hospital. Her PT test values were normal but her PTT test value was 42.6 seconds. The test was not repeated. She was found to have mild uterine atony and responded to conservative treatment. The abnormal PTT test values in this patient could have been due to collection error (specimen handling) or specific inhibitor to factor VIII, which can occur in postpartum females.

Of 34 patients with a history of recent or current use of heparin or oral anticoagulants, 31 patients were given high doses of heparin and/or coumadin on admission. These patients received regular followup PT and PTT tests. Only 1 of these patients developed any coagulation abnormality clinically. Two patients were given mini-doses of heparin but were not followed by a repeat PTT test. One patient was put on prophylactic coumadin and was

not followed with repeat PT tests.

Approximately 90 percent of the patients with coronary artery disease, cerebrovascular accident, or transient ischemic attacks were taking aspirin prior to admission with no complaints of bleeding.

DISCUSSION

PT and PTT tests are very important tests of coagulation. They frequently are routine tests and often are ordered for patients admitted for or undergoing elective surgery.

The AMA, Blue Cross-Blue Shield Association of America, and the Medical Necessity Project created indications for the appropriate ordering of PT and PTT tests.[1,2] Many studies have been done showing that routine PT and PTT testing provides no help in management.[3-6] Screening also cannot help predict postoperative bleeding because most cases of postoperative bleeding are due to causes other than coagulopathy, i.e. surgical technique, medications, or anatomical problems. Even if the patient has coagulopathy, the bleeding usually is not serious. If a proper history and physical examination are done, in approximately 50 percent of the patients, PT and PTT tests would not be required.

Our study further supports this statement because in the majority of the patients where PT and PTT tests were not indicated, normal results were obtained. In the few patients where results were abnormal, no bleeding complications occurred.

It is not useful to order these tests for detecting occult coagulation disorders because PT and PTT tests are not considered good screening tests.[4] A PTT test is a poor predictor of hemorrhagic complications in the ordinary patient undergoing an invasive procedure, but it is a valuable test in high-risk patients with liver disease, coagulopathies, malabsorption, malnutrition, or active bleeding.[7]

A few patients with chronic renal failure showed elevated PT

Table 2. *Results of 195 patients studied.*

Admitting Diagnosis	No. (%) Indicated	No. Not Indicated
Cardiovascular		
Angina and R/O myocardial infarction	7 (24)	22
Myocardial infarction	4 (50)	4
Congestive heart failure	2 (33)	4
Arrhythmias	2 (28)	5
Respiratory		
COPD	0 (0)	4
Pneumonia	3 (43)	4
Hemoptysis	1 (100)	0
Miscellaneous	– –	2
Gastrointestinal		
Bleeding (including hematemesis, perianal bleeding)	9 (100)	0
Gastroenteritis	1 (50)	1
Obstructive bowel disease	2 (50)	2
Acute abdomen	3 (43)	4
Hepatobiliary Disease		
Jaundice	4 (100)	–
Cirrhosis	5 (100)	–
Cholecystitis	– (0)	3
Neurological Problems		
CVA-recent, TIA	10 (100)	–
Meningitis	1 (33)	2
Neuropathies/miscellaneous	2 (67)	1
Seizures	– (0)	2
Renal Disorders		
Renal colic	0 (0)	4
UTI, cystitis	0 (0)	3
Hematuria	3 (100)	0
Chronic renal failure	3 (60)	2
Trauma/Injury		
Submersion	2 (100)	0
Fractures	6 (75)	2
Soft tissue injuries	0 (0)	2
Septicemia		
Wound infection	4 (57)	3
Obstetrical/Gynecological		
Abortion	1 (16)	5
PID	1 (100)	0
Ectopic pregnancy	0 (0)	1
Bleeding		
Cuts and/or other sites	5 (100)	0
Vascular Disease		
DVT/PE	6 (100)	–
PVD	3 (100)	
Others	7 (21)	16
Total	97	98

Table 3. *Specific indications for appropriately ordered PT and PTT tests at the time of admission.**

Indication	Number of Patients with Indications
Evidence of liver disease on history and/or physical examination at the time of admission	13
History of malabsorption or malnutrition	11
Clinical history unavailable at time of admission	4
Active bleeding or evidence of abnormal, excessive, or spontaneous bleeding on physical examination	18
Recent or current use of therapeutic heparin or warfarin	34
Suspected or proved thromboembolism	16
Suspected or proved disseminated intravascular coagulation	2

*Total number of patients with indications displayed in this Table is greater than the total given in Table 2, since some patients had more than one indication.

Table 4. *Summary of PT and PTT test results.*

	PT	PTT
Number of tests performed	195	195
Normal results	149 (76.4%)	184 (94.3%)
Abnormal without any cause	29 (15%)	3 (1.5%)
Abnormal due to drug/disease	17 (8.6%)	8 (4.2%)

values repeatedly. The elevated PT and PTT values in these patients can be due to alteration in coagulation factors including elevated level of factor VIII and inhibitors of plasminogen activation.[8] In our patients, however, the PTT value was normal with normal platelet count. Losowsky and Walls showed a marked decrease in the content of fibrin stabilizing factor XIII in acute and chronic renal insufficiency.[9]

In our study, none of the patients on high doses of heparin developed thrombocytopenia, however, the number was small and patients had not received heparin for very long periods.

CONCLUSION

This study examines the pattern of ordering PT and PTT tests and analyzes their appropriateness. These tests apparently were ordered out of habit, to detect defects in coagulation, or in fear of a malpractice suit. The likelihood that the patient will benefit from this testing is small. These tests frequently are ordered as a preoperative screening test, even though coagulation defect is not a common cause of postoperative bleeding.

A 50 percent reduction (Tables 2 and 3) in PT and PTT testing will not only cut the cost of unnecessary testing, but also will reduce the workload of the already overworked technical staff in a community hospital. ■

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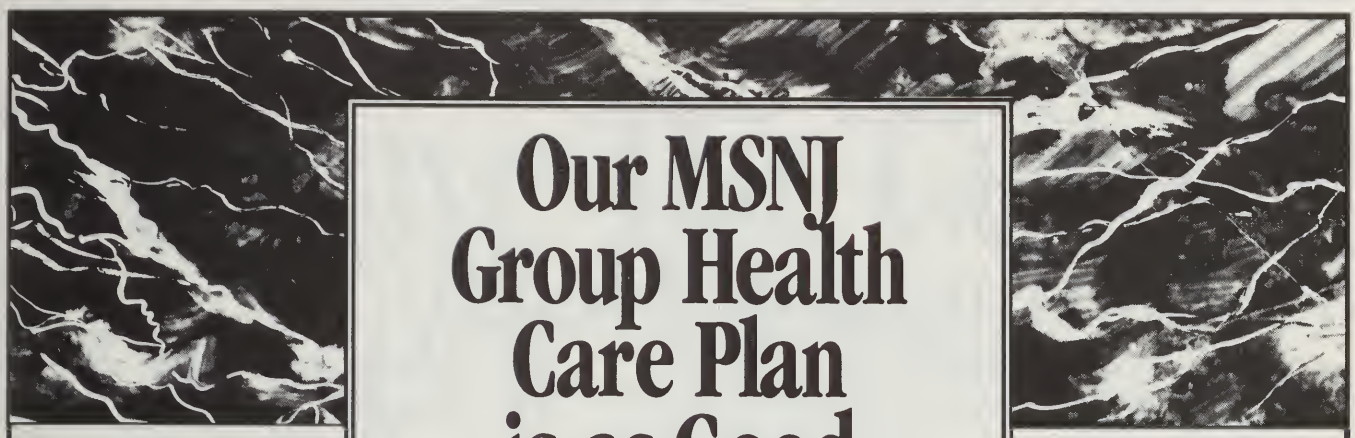
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Drs. Lahoti and Rangwala are affiliated with Monmouth Medical Center.

The paper was submitted in October 1991 and accepted in December 1991.

Address reprint requests to Dr. Lahoti, Monmouth Medical Center, 300 Second Avenue, Long Branch, NJ 07740.



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Why Bother the New Jersey State Department of Health?

Sindy Paul, MD
Carol Ann Genese, MT (ASCP), MBA, CIC
Mary Jane Hung, MSW

The reporting of communicable diseases is a legal and professional responsibility. Individual case reports can be an important piece in a medical puzzle, allowing public health officials to describe new diseases and modes of transmission so preventive measures can be developed and implemented.

In the busy life of clinical practice, one of the lower priorities tends to be the reporting of communicable diseases to a local health department. However, the list of reportable communicable diseases is carefully selected to include only those diseases where public health intervention can prevent the spread of the disease or only those diseases that surveillance can increase the understanding of risk factors.

The current epidemics of AIDS and Lyme disease were described initially in reports to public health authorities. Therefore, even reports of isolated cases can be the piece of a medical puzzle allowing identification of a new problem that will affect clinical practice.

On July 2, 1991, the New Jersey State Department of Health (NJDOH) Public Health and Environmental Laboratories reported receipt of 7 isolates of *Salmonella poona* in June 1991. This represented a significant increase for the state, since only 22 cases have been received in the state laboratory in the previous 14 years. Only 1 case was reported by a physician. Two of these cases actually identified an outbreak that occurred following a christening party and epidemiologically linked another 15 cases. The epidemiologically implicated food was a fruit salad containing cantaloupe, honeydew melon, watermelon, strawberries, grapes, and pineapple. At the same time this outbreak occurred, health departments in 14 other states also were investigating an increased number of *S. poona* isolates. As a result, cantaloupes grown in the Rio Grande Valley of Texas were identified as a source of a multistate *S. poona* outbreak.[1] This multistate investigation resulted in a FDA advisory, recommendations for washing melons before preparation, and time and temperature guidelines.[2]

If primary care physicians had reported cases of this unusual salmonella when diagnosed, an investigation would have been initiated one month earlier, preventive measures based on the investigation could have been implemented about June 15, 1991, and 10 of the 17 percent (59 percent) reported cases might have been prevented.

The *S. poona* outbreak is not an isolated incident in which followup of an unusual disease or isolate resulted in new guidelines for prevention of disease transmission or product recall. In 1990, NJDOH received a report of a foodborne outbreak from a local health department that, in turn, had received a report from a hospital infection control practitioner. The initial report indicated five people developed scombroid after eating grilled tuna steaks. Investigation revealed that the tuna had a positive level of histamine. NJDOH's Consumer Health Service was able to embargo tuna from the store and the distributor before additional tuna could be sold and cause further cases of scombroid.

The reporting of communicable diseases is the professional and legal responsibility of all New Jersey physicians. Case reports can be the pieces of the medical puzzle that help public health officials describe new diseases and modes of transmission so appropriate measures can be developed and implemented. ■

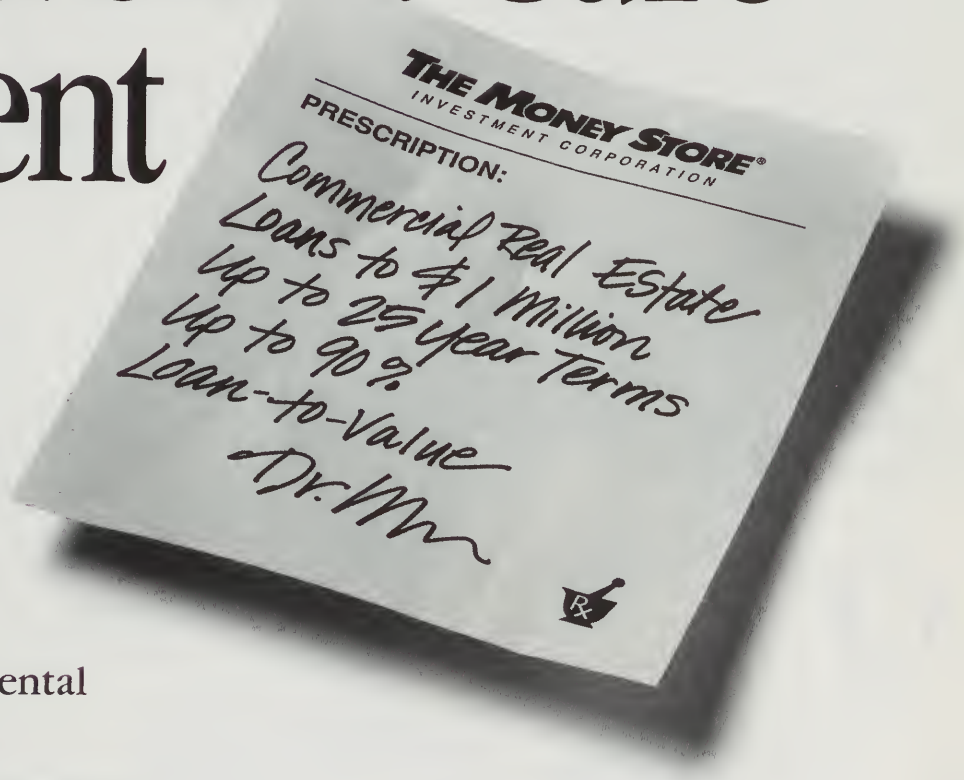
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Dr. Paul, Ms. Genese, and Ms. Hung are affiliated with NJDOH, Division of Epidemiology and Communicable Disease Control. Address reprint requests to Dr. Paul, NJDOH, Division of Epidemiology and Communicable Disease Control, CN 369, Trenton, NJ 08625-0369.

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Phagocytosis of *Candida Parapsilosis* by Polymorphonuclear Leukocytes

Bernard Peison, MD
Bernard Benisch, MD

The authors present a brief case report on an unusual entity. This rare phenomenon observed in a peripheral smear is worth noting. Neutrophils and rare eosinophils show intracellular fungal cells; the size, shape, and budding are consistent with Candida parapsilosis.

Our patient was a 74-year-old icteric white woman with a two-to-four-week history of abdominal pain, nausea, and vomiting due to pancreatic adenocarcinoma with obstruction of the common bile duct. She was placed on antibiotics (gentamycin, mezlocillin, and metronidazole) and a stent was inserted for biliary drainage. The patient began to spike a high fever after placement of the stent. A blood culture revealed a heavy growth of *Candida parapsilosis*. Ciprofloxacin was added and the patient became afebrile. The patient was discharged on total parenteral nutrition. The peripheral smear showed neutrophils and rare eosinophils showing intracellular fungal cells, the size and shape consistent with *Candida parapsilosis* cultured from the blood. Polymorphs showed toxic granulation and Döhle bodies along with the fungal elements (Figure). This case is unusual because phagocytosis by polymorphonuclear leukocytes especially is directed against bacteria and small particles. The authors are not aware of any previous report of phagocytosis of fungi by polymorphonuclear leukocytes. ■

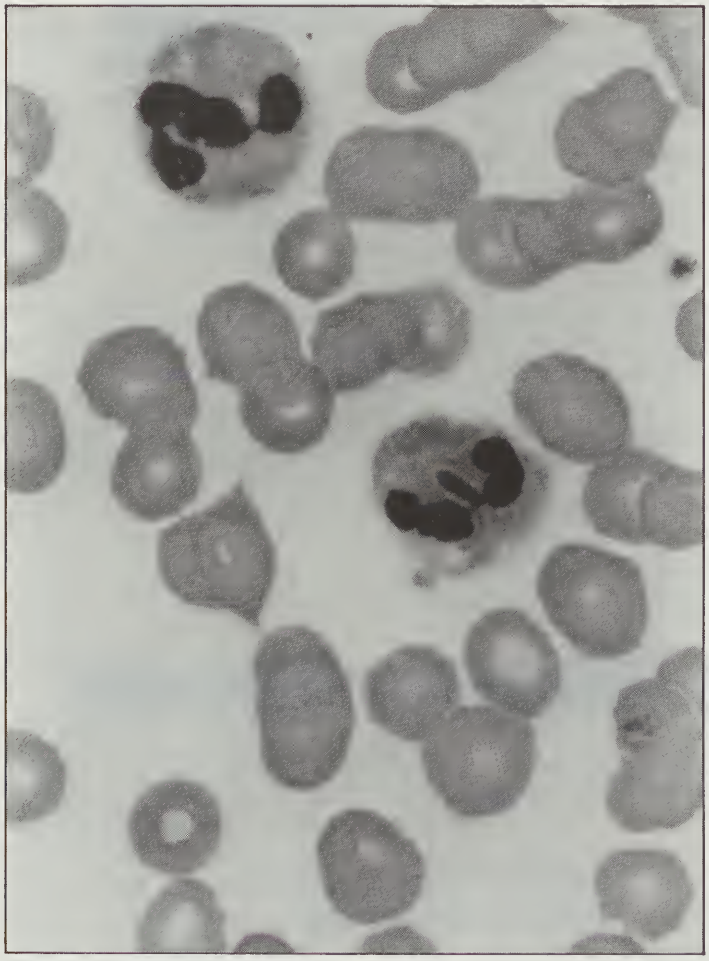
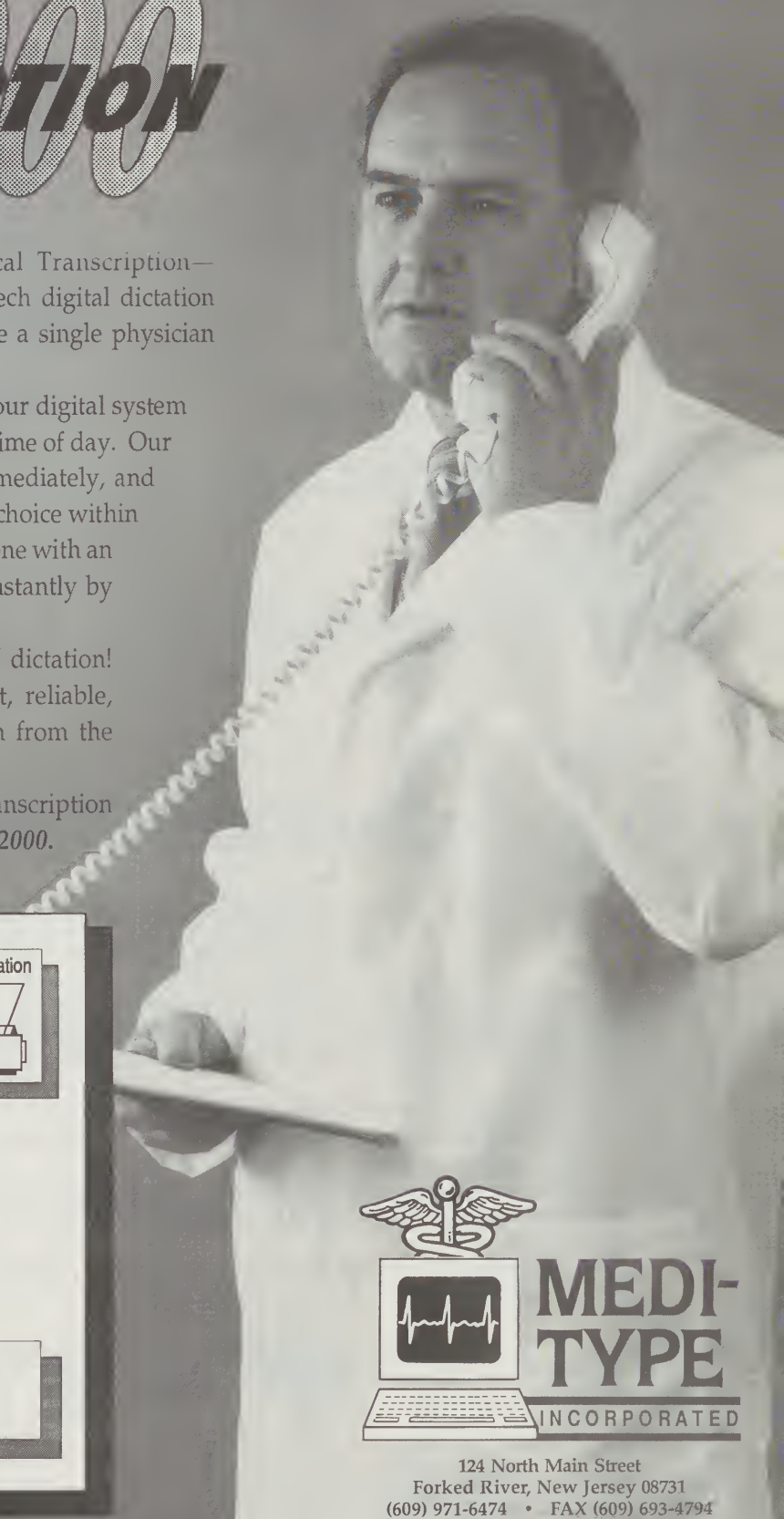


Figure. Peripheral smear.

Drs. Peison and Benisch are affiliated with the Department of Pathology, Rahway Hospital. The paper was submitted in January 1992 and accepted in March 1992. Address reprint requests to Dr. Peison, Rahway Hospital, Rahway, NJ 07065.

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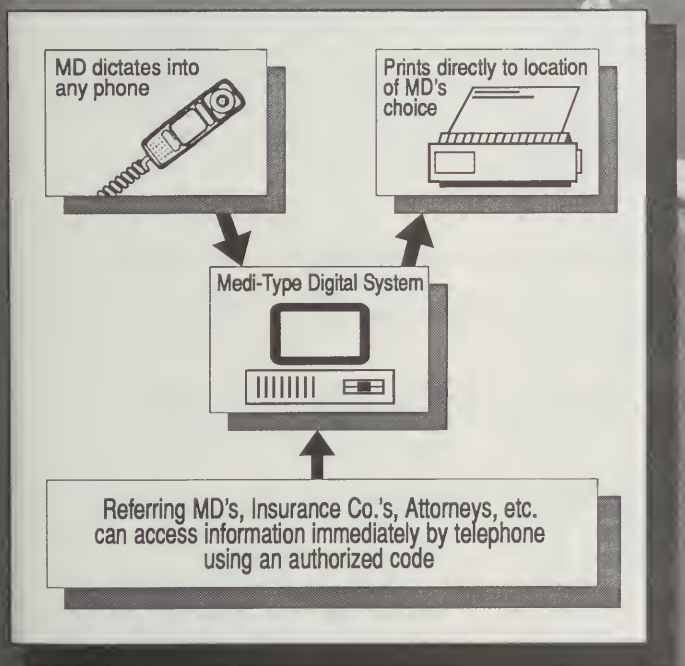


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Medium Chain Acyl-Coenzyme A Dehydrogenase Deficiency and SIDS

Thomas Hegyi, MD
Barbara Ostfeld, PhD
Kathleen Gardner, BSN, MAT

Medium chain acyl-coenzyme A dehydrogenase deficiency (MCADD) is a potentially fatal genetic defect in fatty acid metabolism and may account for a proportion of all deaths initially attributed to sudden infant death syndrome (SIDS). Effective therapy and prevention are available.

The initial suggestion that sudden infant death syndrome (SIDS) may be due to an inherited metabolic disorder came from an investigation by Sinclair-Smith in 1976, who noted that 5 percent of the 200 SIDS cases examined demonstrated diffuse fatty changes in the liver.[1] In 1984, Howatt diagnosed a fatty acid beta-oxidation defect in an infant who died of SIDS.[2] This initial observation was followed by a retrospective study of 200 cases of SIDS that revealed 14 (7 percent) of these infants to have had fatty changes in the liver consistent with a disorder of fatty acid oxidation.[3] Analysis was completed in 9 of the 14 cases that showed 3 cases of medium chain acyl-coenzyme A (acyl-CoA) dehydrogenase deficiency (MCADD) and 1 case of long chain acyl-CoA dehydrogenase deficiency (LCADD).[4]

While these results suggest that these disorders may be responsible for 2 to 7 percent of all SIDS deaths, other investigators have proposed the frequency of these defects to be higher. In 1990, Harpey presented the results of metabolic studies on 189 siblings of SIDS victims and on 84 infants following an apparent life-threatening episode.[5] The incidence for a disorder of fat oxidation was 15 percent and 17 percent in the two groups, respectively. Among 28 siblings of SIDS with abnormal metabolic results, there were 12 cases of MCADD and among the 14 abnormal ALTE infants, 5 cases were present.

We present a review of fat in infant nutrition, focusing on free fatty acids, and to describe the metabolic basis, clinical manifestations, diagnosis, and therapy of the most common defect in mitochondrial fatty acid oxidation, MCADD.

FAT AVAILABILITY, ABSORPTION, AND METABOLISM

Fats or lipids are nonpolar substances, insoluble in aqueous media and essential for normal growth and development. As part of its general function, fats contribute 40 to 50 percent of total calories in human milk or formula; form an integral part of cell membranes; provide substrates for neural tissue development; act as vehicles for essential biologic components, such as vitamins and hormones; and serve as body stores of energy.[6] The major classes of lipids are glycerides, phospholipids, sterols, and free fatty acids. Glycerides, a combination of gylcerol and fatty acids, are the most abundant fat in human tissue, and serve as a reservoir for fatty acids and as metabolic intermediates. The phosphorus-containing phospholipids are key components of cell membrane structure and lung surfactant. Cholesterol, the principal sterol, is an integral element in the structure of cell membranes and lipoproteins and acts as the parent compound for steroid hormones. The degradation products of cholesterol are important in the digestion and absorption of all lipids.

Fatty acids of animal derivation usually are unbranched, monocarboxylic acids comprised of an even number of carbon atoms, varying from 2 to 24 in chain length (Table 1). Fatty acids may be saturated or unsaturated, with double or triple bonds existing between specific carbon atoms (Table 2). Storage lipids usually contain higher concentrations of saturated fatty acids than structural lipids. The approximate composition of fatty acid mixtures from human depot fat is 3 percent myristic (14:0 or 14 carbon atoms with 0 double bonds), 23 percent palmitic (16:0), 6 percent stearic (18:0), 5 percent palmitoleic (16:1), 50 percent oleic (18:1), and 10 percent linoleic (18:2).[7]

The fat content of human milk ranges from 3.5 to 4.5 percent. While this composition changes during the different periods of

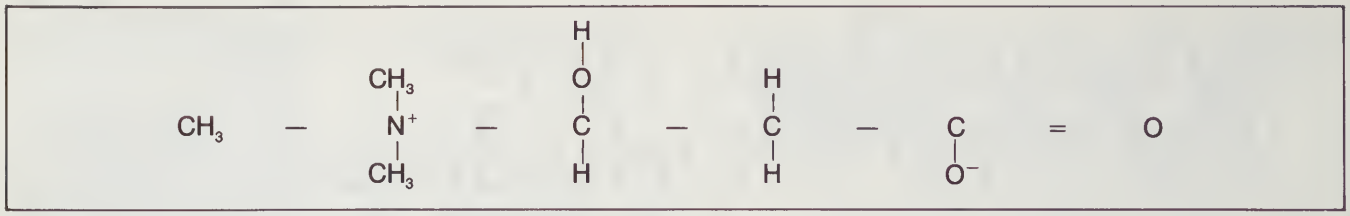


Figure 1. Carnitine—trimethylamino–β–hydroxybutyrate.

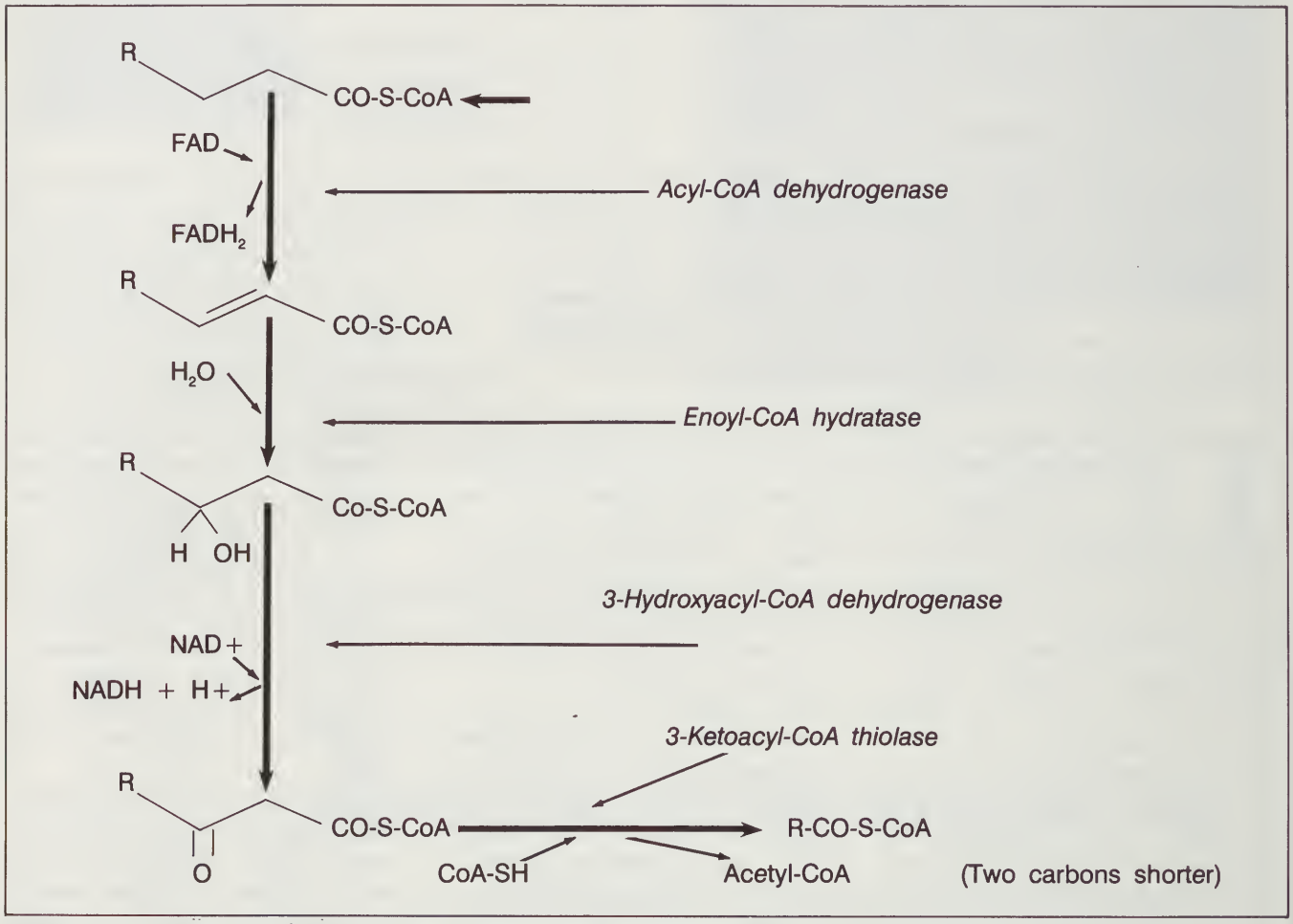


Figure 2. Pathway of fatty acyl-CoA oxidation in mitochondria.

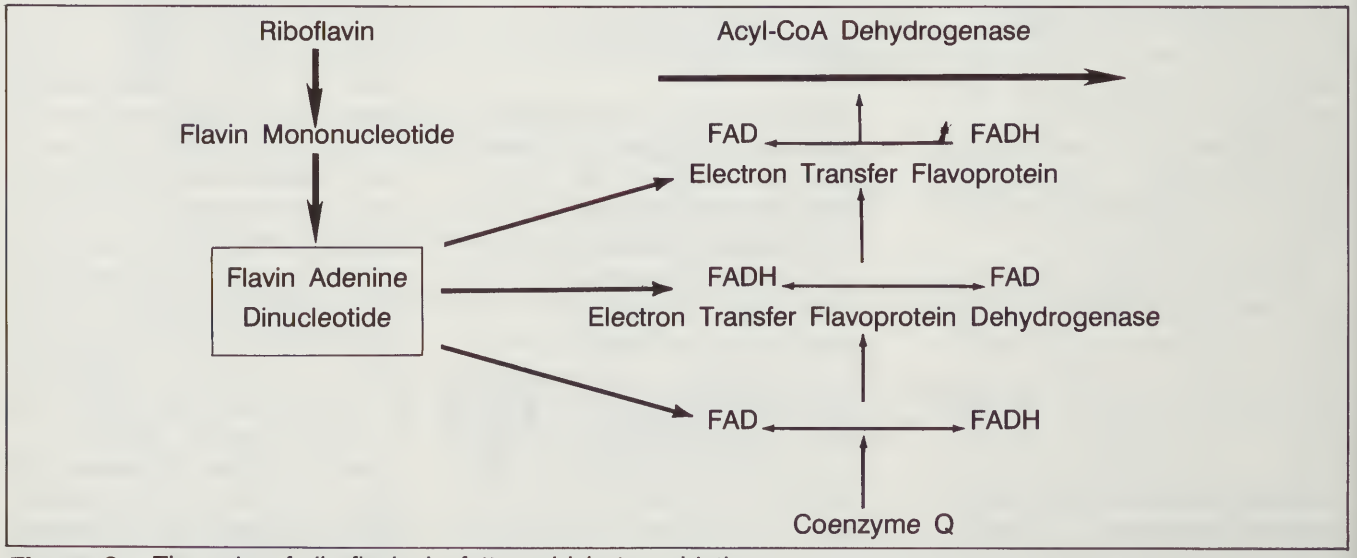


Figure 3. The role of riboflavin in fatty acid beta oxidation.

lactation (early lactation or colostrum, transition to mature milk, and weaning), mature milk preserves a consistent fat proportion.[8] Eleven major fatty acids, ranging from capric (10:0) to arachidonic (20:4), constitute 98 percent of the fat content. The five most abundant fatty acids in human milk at term are oleic (18:1), making up approximately 34 percent, palmitic (16:0) at 22 percent, linoleic (18:2) at 16 percent, myristic (14:0) at 6 percent, and lauric (12:0) at 5 percent. Fifty-seven percent of the fatty acids are unsaturated.[9]

The principal distinction between the fat in human milk and in infant formulas is the absence in formulas of long chain polyenoic fatty acids greater than 18 carbon chain in length. In addition, the constant rate of fat delivery in the formulas contrasts with the marked variation of fat content in human milk; lowest in fore milk, highest in hind milk, and lowest in early morning.[6]

The majority (more than 95 percent) of dietary fat from human milk and infant formula is in the form of triglycerides. In the luminal phase of digestion, lingual and gastric lipases in the stomach and pancreatic lipase in the small intestine catalyze the breakdown of triglyceride to glycerol and free fatty acids.[10] This reaction is assisted by bile salts that emulsify and solubilize the triglycerides. The short and medium chain fatty acid products of this hydrolysis pass into the intestinal cell by passive diffusion and then are transported to the liver via portal blood. Following absorption, the long chain fatty acids are reconverted to triglycerides in the intestinal mucosal cell following activation to acyl-CoA, a mitochondrial step catalyzed by acyl-CoA ligase. The re-esterification to triglyceride proceeds by way of two mechanisms, the monoglyceride and phosphatidic acid pathways. A monoglyceride is the fatty acid acceptor in the former reaction and accounts for approximately 70 percent of the re-esterification. A glycerophosphate is the fatty acid acceptor in the phosphatidic pathway and is the sole mechanism for phospholipid generation in the intestinal mucosa. The newly created trigylceride is combined with phospholipid, cholesterol, and protein, and assembled into lipoproteins, chylomicrons, and very low density lipoproteins (VLDL). These lipids then are released into the lymph, and transported via the lymphatic system into the circulation.[7]

Lipoprotein lipase is the key enzyme in removing triglyceride from the chylomicron and in hydrolyzing triglyceride to free fatty acid and monoglyceride. It is active at the endothelial wall of tissues and its location facilitates the uptake of these products into the tissues. Another lipase that hydrolyzes lipoprotein triglyceride is hepatic lipase, located in the endothelium of liver capillaries. The released fatty acid then can be taken up by peripheral tissues where it can be deposited in adipose tissues, oxidized, or reincorporated into lipoproteins.[8]

Carnitine is essential for the catabolism of long chain fatty acids (Figure 1).[11] It is synthesized in the liver and kidney from amino acids lysine and methionine, a reaction that is not fully developed in the newborn. The inner mitochondrial membrane surrounding the mitochondrial matrix enzymes for beta-oxidation is impermeable to long chain fatty acids. Medium chain fatty acids can enter the mitochondria without the need for carnitine-mediated transfer. Carnitine serves as a carrier of the long chain free fatty acids after forming a complex with the fatty acid derivative of CoA (Table 3). This reaction is mediated by carnitine palmitoyl transferase I. Following passage of the complex through the inner mitochondrial membrane, carnitine palmitoyl transferase II separates carnitine from the acyl-fatty acid.

Table 1. *Naturally occurring saturated fatty acids.*

$CH_3(CH_2)nCO_2H$

Acetic acid	n = 0
Propionic acid	n = 1
Butyric acid	n = 2
Carpoic acid	n = 4
Caprylic acid	n = 6
Capric acid	n = 8
Lauric acid	n = 10
Myristic acid	n = 12
Palmitic acid	n = 14
Stearic acid	n = 16
Arachidic acid	n = 18
Behenic acid	n = 20
Lignoceric acid	n = 22
Cerotic acid	n = 24
Montanic acid	n = 26

Table 2. *Naturally occurring unsaturated fatty acids.*

Crotonic acid	$CH_3CH=CHCO_2H$
Palmitoleic acid	$CH_3(CH_2)_5CH=CH(CH_2)_7CO_2H$
Oleic acid	$CH_3(CH_2)_7CH=CH(CH_2)_7CO_2H$
Linoleic acid	$CH_3(CH_2)_3(CH_2CH=CH)_2(CH_2)_7CO_2H$
Linolenic acid	$CH_3(CH_2CH=CH))_3(CH_2)_7CO_2H$
Arachiodonic acid	$CH_3(CH_2)_3(CH_2CH=CH)_4(CH_2)_3CO_2H$
Nevonic acid	$CH_3(CH_2)_7CH=CH(CH_2)_{13}CO_2H$
Ximenynic acid	$CH_3(CH_2)_5CH=CH-C=C-(CH_2)_7CO_2H$
Mycomycin acid	$HC=CC=C-CH=C=CH-CH=CH-CH=C HCH_2CO_2H$

Table 3. *Fatty acid activation conversion to the acyl derivative of CoA.*

Acetate thiokinase
Activates acetate, propionate, and acrylate

Medium chain thiokinase
Activates fatty acids with 4-12 carbon atoms, benzoate unsaturated acids, hydroxyacids, and others

Long chain thiokinase
Activates fatty acids containing up to 22 carbon atoms

Thiophorase
Interconversion of acyl-SCoA and free acid

GTP-specific acid thiokinase
Requires GTP as coenzyme

Table 4. *Carrier frequency of the abnormal MCAD gene.*

Center	No. Infants	Homo-zygote	Hetero-zygote	Frequency
Birmingham	479	0	12	1/40
Melbourne	353	0	5	1/71
Houston	536	0	5	1/107
Sendai	500	0	0	

Table 5. *Metabolic consequences of MCADD.*

- Reduced ketone body production
- Lower citrate concentration
- Compromised malonyl-CoA synthesis
- Decreased tricarboxylic acid cycle activity
- Reduced malate and glucose availability

Fatty acid oxidation is essential in the production of energy, especially important during periods of reduced nutritional intake. During these episodes of fasting, the muscles of the body, including the heart, preferentially utilize fat for energy requirements. This leads to the preservation of the glucose supply for tissues with high glucose demand, such as the brain and red blood cells. The liver is a central mediator in the adaption to starvation, and the metabolites of fatty acid oxidation, acetyl-CoA, ATP, and NADH, play key functions: increasing hepatic gluconeogenesis to assure a constant supply of glucose after depletion of glycogen stores, and increasing ureogenesis to accommodate increased protein catabolism. In addition, acetyl-CoA is employed for ketone production, which becomes an auxiliary source of energy for skeletal and cardiac muscle and, later, for the brain.

This adaptation to fasting is dependent on the integrity of the biochemical pathways of fatty acid beta-oxidation (Figure 2).[12] The initial step of this reaction is the formation of a double bond in the 2-3 position by an acyl-CoA dehydrogenase. Three separate dehydrogenases have been identified with overlapping substrate specificity for long, medium, and short chain acyl CoA esters. A common electron transfer chain, consisting of electron-transfer flavoprotein and electron-transfer flavoprotein dehydrogenase, is used by these three dehydrogenases to transfer their electrons to the respiratory chain, at the ubiquinone level. The vitamin riboflavin plays an essential role in the generation of the nucleotides necessary for these reactions (Figure 3).[13]

The ultimate product of the beta-oxidation process, acetyl-CoA, is formed by the successive steps of three enzymes that follow the dehydrogenases: enoyl-CoA hydratase, 3-hydroxyacyl-CoA dehydrogenase, and a thiolase. There are three dehydrogenases, each acting on fatty acids of differing chain length. The maximal activity of short chain acyl-CoA dehydrogenase (SCAD) is on a 4 carbon fatty acid, the medium chain dehydrogenase (MCAD) on an 8 carbon chain length, and the long chain dehydrogenase (LCAD) on a 14 carbon chain length. All of these enzymes, however, have overlapping activities.

The MCAD enzyme is a tetramer with each subunit weighing 44,000 daltons for a total molecular weight of 178,000 daltons. Each subunit contains one molecule of flavin adenine dinucleotide. The enzyme is synthesized on the cytoplasmic ribosomes as a 50-dDA recursor. Current molecular biology techniques have assigned the cloned DNA to the short arm of chromosome 1, band p31 of the human genome.[14]

Odd chain free fatty acid oxidation proceeds in a similar manner until the three carbon moiety, propionyl-CoA, is formed, which then is degraded by the biotin dependent enzyme propionyl-CoA carboxylase. Following action by two additional enzymes, methylmalonyl-CoA racemase and methylmalonyl-CoA mutase, the final product of this pathway is succinyl-CoA, which then enters the tricarboxylic acid cycle.

Unsaturated fatty acids employ the standard beta oxidation pathway until the reaction reaches a double bond.[12] At this point, the double bond is eliminated by the action of three enzymes, enoyl-CoA isomerase, 2,4-dienyl-CoA reductase, and enoyl-CoA hydratase, followed by the resumption of the standard pathway.

The regulation of fatty acid oxidation is under the control of insulin and glucagon.[15] Insulin in-

hibits lipolysis of adipose tissue, decreases the level of free fatty acids available for metabolism, stimulates acetyl-CoA carboxylation and lipogenesis, and increases the levels of malonyl-CoA. Malonyl-CoA is a potent inhibitor of carnitine palmityl transferase I and, therefore, a suppressor of fatty acid oxidation. Glucagon stimulates oxidation via the same pathway by reducing the level of malonyl-CoA.

There are several alternate pathways for fatty acid oxidation. Alpha oxidation, the removal of single carbon units, has been demonstrated in the brain microsomes.[16] Alpha hydroxy long chain fatty acids are constituents of brain lipids and are converted to alpha keto acids, followed by oxidative decarboxylation. Omega oxidation results in omega

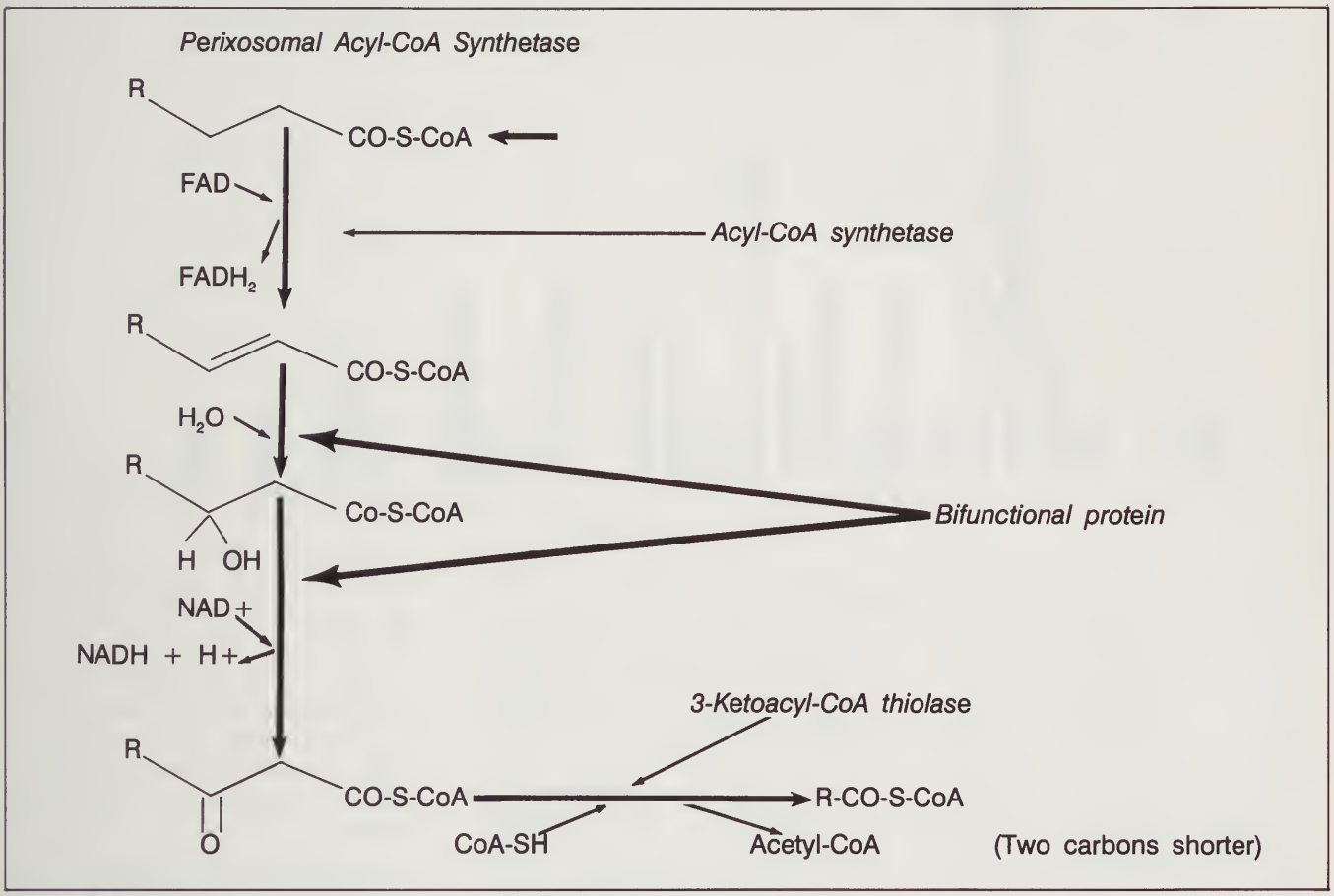


Figure 4. Pathway of fatty acyl-CoA oxidation in perixosomes.

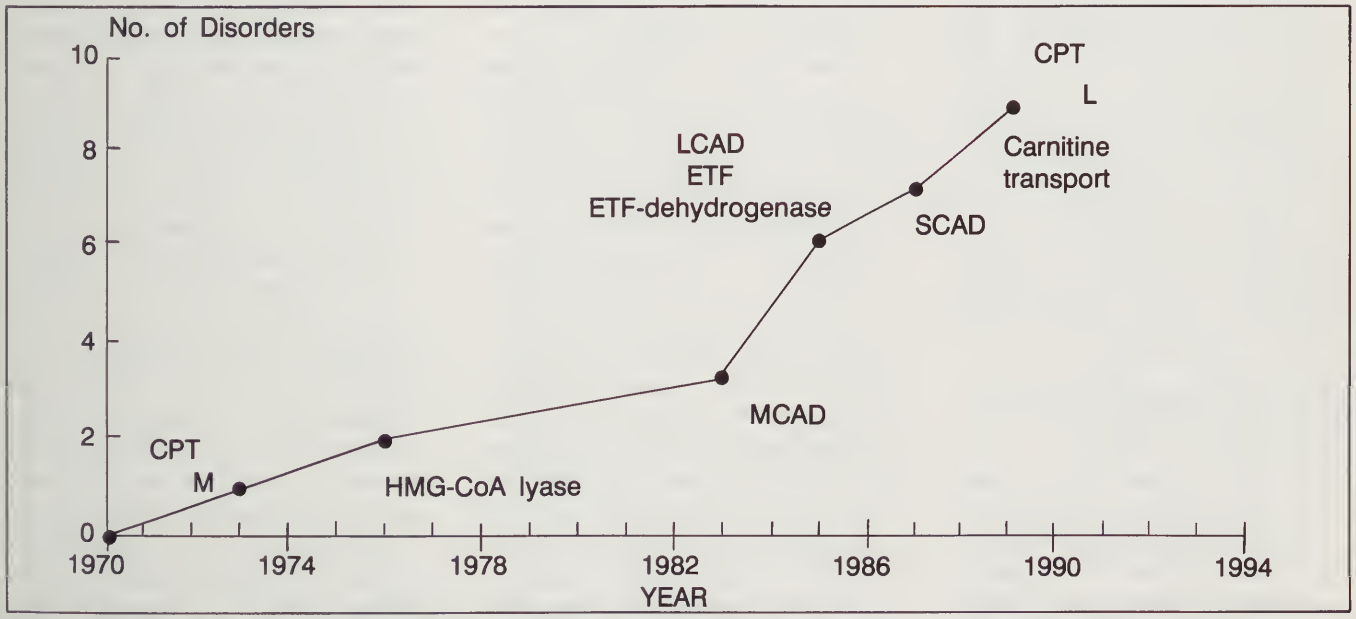


Figure 5. First reports of defects in fatty acid oxidation.

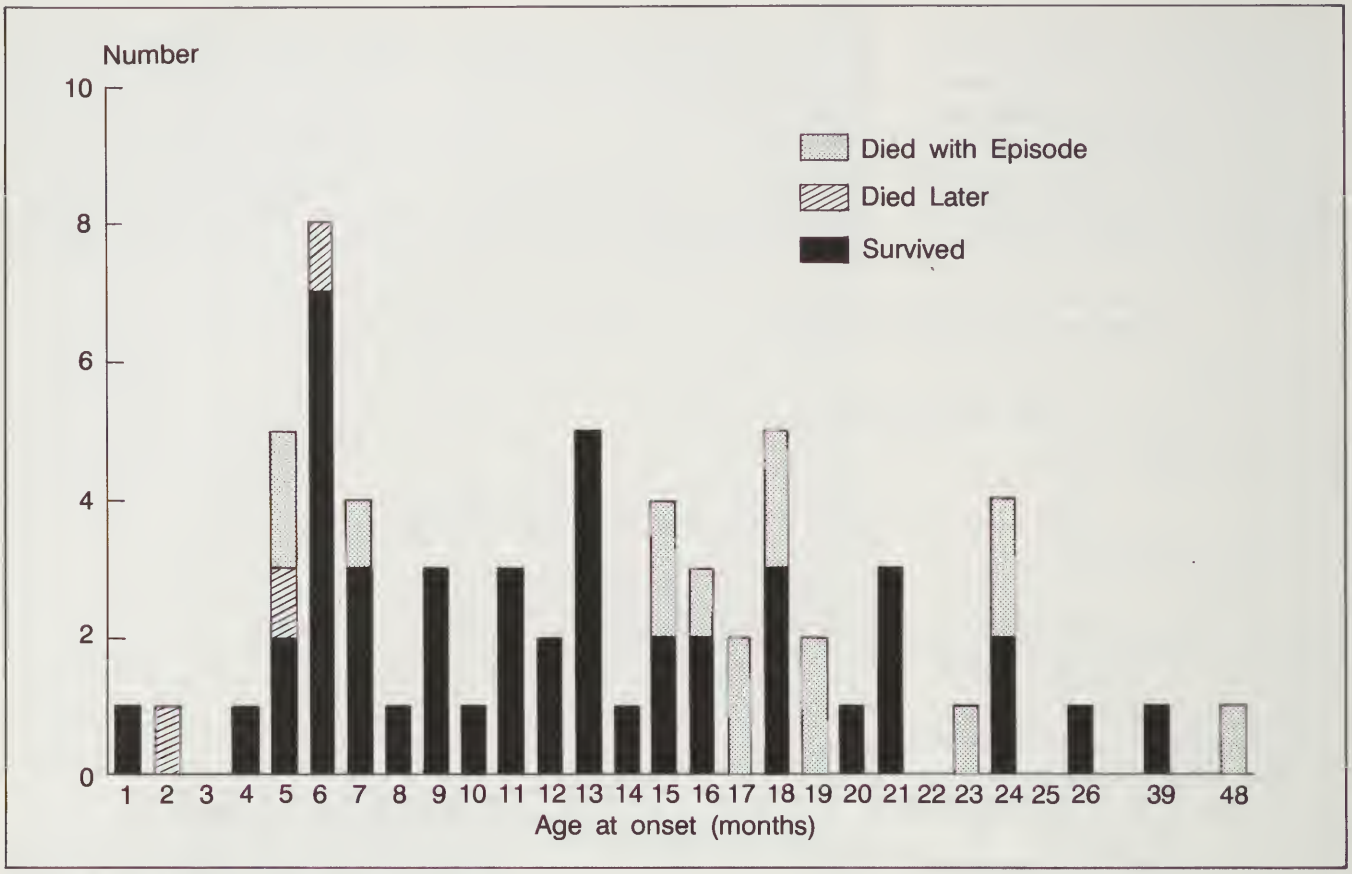


Figure 6. MCADD: Onset and mortality.

hydroxy fatty acids, first converted to dicarboxylic acids, then shortened by beta oxidation.[17]

Another alternate system of oxidation occurs in the perixosomes, cytoplasmic organelles separate from the mitochondria.[12] This is a carnitine independent reaction that proceeds without medium chain acyl-CoA dehydrogenase (Figure 4). Since perixosomes do not possess tricarboxylic acid cycle or electron transport system, the products of oxidation are transported to the mitochondria. The activity of this system changes in response to alterations in various physiologic and pathologic conditions, such as ingestion of a high-fat diet, fasting, diabetes, and mitochondrial enzyme deficiencies.

INBORN ERRORS OF FATTY ACID OXIDATION

During the past decade, several defects of fatty acid oxidation have been identified (Figure 5): carnitine deficiency, primary or secondary; carnitine palmityl transferase (CPT) deficiency; long chain acyl-CoA dehydrogenase deficiency (LCADD); medium chain acyl-CoA dehydrogenase deficiency (MCADD); short chain acyl-CoA dehydrogenase deficiency; electron-transfer flavoprotein deficiency; electron-transfer flavoprotein dehydrogenase deficiency; long chain 3-hydroxyacyl-CoA dehydrogenase deficiency; and multiple acyl-CoA dehydrogenase deficiency.[18]

The most common clinical presentation of these inherited disorders of fatty acid beta-oxidation is hypoketotic-hypoglycemic attacks, precipitated by upper respiratory tract infection, immunization, or abnormal periods of fasting in a previously apparently healthy infant. The disease can mimic a Reye-like syndrome with acute vomiting, lethargy, progressive obtundation, and with signs of hepatic dysfunction. These episodes often are so rapid in their development that they may not be apparent and the infant, who dies suddenly and unexpectedly, receives the diagnosis of SIDS.

MCADD

Among the disorders of fatty acid beta-oxidation, MCADD is the most frequently recognized, with over 100 children identified with the disorder. In 1989, the frequency of the illness was estimated to be between 1 in 10,000 in the United States and 1 in 25,000 in the United Kingdom. In 1991, the results of a study utilizing genetic diagnostic methods predicted an incidence of homozygotes for the common mutation to be 1 in 6,400 in white population.[19] Since a small proportion (10 to 15 percent) of affected patients are not homozygous for this mutation, it is likely that the frequency is as high as 1 in 6,000. It is important to emphasize that this frequency is approximately twice that of phenylketonuria, a disease considered to occur in sufficient frequency to warrant routine neonatal screening. Matsubara demonstrated the carrier frequency of the abnormal MCAD gene (Table 4).[19]

The clinical presentations of

MCADD are similar to those of the other defects of fatty acid oxidation, and include acute encephalopathy and hepatomegaly often mistaken for Reye's syndrome, SIDS, and apparent life-threatening events. These episodes are characterized by hypoketotic hypoglycemia. Symptoms usually are triggered by fasting or infection; at other times, the patients remain well and often symptom free. Examination may reveal the presence of hepatomegaly, due to fatty changes. Approximately 60 percent of patients with the deficiency die during the first clinical episode (Figure 6).

During fasting, medium chain acyl-CoA intermediates accumulate, at the expense of free CoA. As a consequence of the reduced amounts of CoA, conversion of pyruvate to acetyl-CoA is reduced, citrate synthesis is compromised, flux from alpha-ketoglutarate to succinyl-CoA is impeded, and flow through the tricarboxylic acid cycle is reduced. With lack of a substrate, ketone body formation in the liver is decreased (Figure 7). Acetyl-CoA is transported out of the mitochondria as either acetylcarnitine or citrate. With acetyl-CoA reduced, citrate is unavailable to be converted to oxaloacetate, further compromising the tricarboxylic acid cycle. Acetyl-CoA derived from citrate in the cytosol serves as a substrate for acetyl-CoA carboxylase, the enzyme responsible for the synthesis of malonyl-CoA, the primary regulator of CPT I. The inadequate levels of malonyl-CoA result in the unregulated entry of free fatty acids into the mitochondria and the increased production of medium chain acyl intermediates. Finally, the reduced levels of acetyl-CoA compromise the action of pyruvate carboxylase that results in the reduction of malate, a precursor of glucose (Table 5).

The mechanism for the clinical presentation can be explained on the basis of these metabolic consequences of the deficiency. The hypoglycemia is due to the compromised gluconeogenesis. The encephalopathy and cerebral edema are produced by the acyl compounds that have encephalopathic properties including EEG changes. Their entry into the central nervous system is facilitated by increasing chain length. Octanoate inhibits the choroid plexus' organic anion uptake system, which is responsible for the release of compounds from the central nervous system. Octanoic acidemia damages neuronal mitochondria, resulting in the depression of energy metabolism and the reduction of the availability of high energy phosphate compounds.

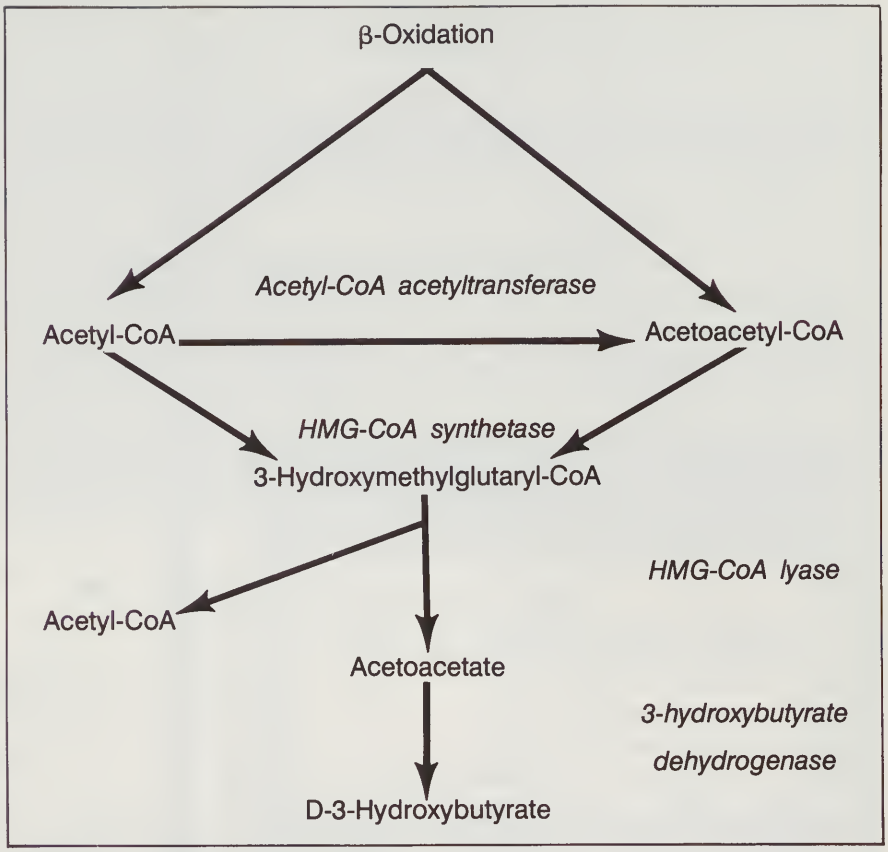


Figure 7. Hepatic ketogenesis.

There are several methods for the diagnosis of MCADD. Laboratory findings include the presence of hypoketotic hypoglycemia and lactic acidosis. The blood ammonia levels and liver function studies usually are normal.

Organic acid analysis reveals metabolites of the acyl CoA intermediates that accumulate proximal to the site of the metabolic defect, which vary greatly and can include CoA thioesters, partially oxidized medium chain fatty acids, and medium chain dicarboxylic acids that are the products of omega oxidation.

There are several approaches to the measurement of these metabolites.[5,12] For example, octanyl carnitine is measured with mass spectrometry and cis-4-decenoic acid is detected with gas chromatography. The accuracy of these in vivo analyses is improved following loading tests to stress the suspected metabolic pathways and fasting studies to test the adaptation to this state. In vitro measures include oxidation of radio-labelled free fatty acids by either tissue homogenates or intact cultured skin cells and the direct detection of enzymes in biopsy tissues or fibroblasts. Fibroblasts from MCADD patients oxidize octanoic acid (14:0) at 20 percent of control rates (Table 6).

These laboratory methods often are difficult, expensive, and tech-

Table 6. *Enzymatic diagnosis of MCADD.*

ETF Based
Oxidized electron transfer flavoprotein (fluorescent) is reduced by electrons from acyl-CoA during the dehydrogenation reaction—ETF fluorescence declines at a rate proportional to the transfer of electrons.

ETF Linked Dye Reduction
Based on transfer of electrons to artificial electron receptors, such as dichlorophenolindophenol (DCPIP) or phenazine methosulfate (PMS).

GC-MS Technique
Measures the concentration of enyl-CoA, the metabolite formed by the dehydrogenation of acyl-CoA.

Tritium Release Method
Measures formation of tritiated water from the ^{3}H released as [2,3-3H], acyl-CoA substrate is dehydrogenated.

nologically demanding. The simplest way to identify the predominant MCAD mutation is the deoxyribonucleic acid (DNA) analysis of tissue or blood.[19] The MCAD gene has been fully identified and sequenced.[14] A single mutation of an A-to-G nucleotide at position 985 leads to the substitution of lysine by glutamic acid at the amino acid residue 329 of the MCAD precursor protein. The polymerase chain reaction assay utilizing this specific probe can detect approximately 85 percent of the infants with MCADD, the proportion of patients with the deficiency who are homozygous for this single mutation. The DNA testing for this point mutation, designated K329E, does not eliminate false negative results since not all mutations that cause MCADD are detected by this probe.

Management consists of providing adequate calorie intake with a diet moderately high in glucose. During episodes of fasting or vomiting, intravenous glucose infusion is warranted.

Oral L-carnitine supplementation is important to combat the acquired carnitine deficiency seen in the disorder as well as for its detoxification effects.[20,21] The drug enhances the urinary excretion of toxic acyl-CoA compounds as acylcarnitines. However, bacterial destruction of carnitine in the intestine and the compromised absorption of oral L-carnitine may require administration via the intravenous route in symptomatic infants. ■

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Drs. Hegyi and Ostfeld and Ms. Gardner are affiliated with the Division of Neonatology, St. Peter's Medical Center, UMDNJ-Robert Wood Johnson Medical School, and the New Jersey Sudden Infant Death Syndrome Resource Center, New Brunswick. Address reprint requests to Dr. Hegyi, St. Peter's Medical Center, 254 Easton Avenue, New Brunswick, NJ 08903.

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AT THE
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The Diagnosis and Management of Depression: An Overview

Philip H. Witt, PhD
Daniel P. Greenfield, MD, MPH, MS
Jeffrey A. Brown, MD, JD, MPH

The authors present an overview of the diagnosis, treatment, and management of depressed patients. They discuss current psychotherapeutic techniques, the psychopharmacologic management of depression, and guidelines for referral of depressed patients to mental health professionals.

Depression has been called the common cold of mental health problems. A significant proportion of the population will experience depression and many of these depressed persons will require treatment. In fact, recent studies indicate that, conservatively, at least 4 percent of the population is depressed at any given time to warrant clinical intervention, and that at least 20 percent of the population will require intervention for depression at some time.[1,2] Depression is more common in women than in men. Approximately 25 percent of the women in the United States will experience depression at some time in their lives, and twice as many women as men will be hospitalized for depression.[3,4] Approximately 10 percent of the college population report moderate depression, and approximately 5 percent of the college population report severe depression.[5]

RELEVANCE TO THE PHYSICIAN

The primary care physician frequently is the first treatment contact for a depressed patient.[6] Such patients may present with a variety of symptoms, including somatic symptoms, which the patient believes to be the result of a physical illness. In actual practice, an unhappy appearance or unhappy mood frequently masks other symptoms.[7] One patient may present with various somatic complaints that initially appear to be the result of a somatic illness; a second patient may describe a sleep disturbance that appears to be secondary to anxiety; another patient may present with a low energy level that mimics a low-grade systemic infection. Only after a careful interview where the examining physician is alert to the signs and symptoms of depression, may the prevailing unhappy mood become evident. Some "alexithymic" depressed patients, in fact, may find themselves experiencing little emotion and are unable to articulate their mood disturbance when interviewed.[8]

The most common symptom associated with depression is anxiety. One study has shown that measures of anxiety and depression are highly correlated (+0.60).[5] Consequently, the physician must be alert for anxiety that either masks or is comorbid with depression. Perhaps the most common clinical error in evaluating a patient for depression is diagnosing an anxiety disorder, and frequently prescribing a benzodiazepine, when the patient's psychiatric problem is not based on anxiety, but is rather caused by depression. In these situations, benzodiazepines may serve only to aggravate the underlying depression.[9]

Over the years, a good deal of research has been done to evaluate the subjective symptoms experienced by depressed patients. Although a depressed mood, i.e. dysphoria, certainly is a common symptom in depression, many other important symptoms have been found in depressed patients. Factor analytic studies have classified these symptoms of depression into six areas with important implications in the psychotherapeutic treatment of depression:[10]

1. Dysphoria. Dysphoria, perhaps, is the most prominent indicator of depression, and certainly is the symptom most clearly linked to that disorder by laymen. Frequent crying, pessimism, hopeless future expectations, and feelings of worthlessness are facets of dysphoria.

2. Reduced rate of behavior. Depressed persons do less than they did when they were not depressed. They tend to withdraw from previously enjoyable hobbies or interests, and describe these activities as tedious. A depressed person may spend his

day in passive solitary activities, such as watching television, sleeping, or gazing aimlessly out the window.

3. Social-interaction problems. Depressed persons frequently withdraw socially. They isolate themselves from friends, relatives, and acquaintances. Some become irritable and antagonistic with others, and marital problems may develop as a result, as may problems in the workplace.

4. Guilt. Guilt is common among depressed persons. Some depressed persons believe they are not adequately fulfilling various obligations, despite ample evidence to the contrary. Some such individuals believe they deserve to be depressed to atone for imagined misdeeds.

5. Material burden. Some depressed persons attribute their depression to external material circumstances, e.g. work disturbances, marital problems, financial constraints. Such persons frequently propose that if their material problems were resolved, their depression no longer would exist.

6. Somatic complaints. Depressed persons commonly develop a litany of somatic problems. Some problems are a direct consequence of the depression, such as delayed sleep onset, early awakening, and loss of appetite and weight; other such problems may be a more indirect result of the general stress and malaise that accompany depression, such as fatigue, headaches, and gastrointestinal problems. This category of complaints constitutes the "vegetative," "neurovegetative," or "biological" indicators of depression that are amenable to pharmacologic intervention.

EXPECTATIONS FROM PSYCHOTHERAPY

When a primary care physician refers a depressed patient for psychotherapy, he should be aware that many therapeutic approaches to treatment may be used, some standardized and respected, others not. However, the informed physician should realize that two therapeutic approaches have been specifically developed in the field of psychiatry and psychology to treat depression: cognitive-behavior therapy[11] and interpersonal therapy.[12] Both of these approaches have been subjected to extensive empirical studies for efficacy, both by the originators of these techniques and, more recently, through National Institute of Mental Health–sponsored multisite field trials. The results of these studies indicate that both approaches are effective treatments for depression.[13-16]

Cognitive-behavior therapy generally treats depression as the result of interactions of negative cognitions and a reduced rate of pleasure-producing actions. These negative cognitions are characterized by the "depressive cognitive triad," or a negative view of the self; of the world; and of the future.[17] This cognitive triad is manifested through depressive, nonreflexive, habitual, and automatic thoughts. For example, when confronted with stress, a depressed patient may say, "I can't handle it. I'll fail as I always have before. I'm just not up to it. Why bother trying? It's no use!" These negative automatic thoughts lead to a decreased rate of active coping behaviors and, as a result, the depressed person becomes isolated, withdrawn, and lethargic.

Both cognitive and behavioral interventions may occur in a given case. Direct cognitive interventions assist the patient to alter negative automatic thoughts. These interventions may range from having the patient objectively examine the evidence for negative thoughts, to learning to label the dysfunctional patterns (such as overgeneralizing or dichotomous thinking) that characterize these negative thoughts, to writing alternative realistic thoughts. Behavioral interventions help the patient cope more effectively by encouraging the patient to take active, productive action. The therapist, for example, may have the patient rehearse assertive acts, develop a concrete plan to be less isolated (consisting of graded behaviors beginning with those within the patient's ability), or keep an activity log, rating activities with regard to feelings of pleasure or mastery. In addition—particularly if anxiety is a concomitant of depression—the therapist may instruct the patient in relaxation training[18] or guided coping imagery.

Currently practiced, interpersonal therapy views depression as emerging from four broad areas: grief, particularly the death of a loved one; interpersonal problems with significant others, such as a spouse, employer, or relatives; role transitions, including changing jobs, relocating, entering a new phase of life; and interpersonal deficits, especially those leading to social isolation.[12]

Obviously, these problems are not mutually exclusive, so that patients often present as having a combination of these difficulties. A family physician, for example, may see a patient whose spouse has just died and who has conflicts with children over settlement of the estate. Generally, the more areas a patient is disturbed, the more severe the reactive depression he will experience. Interpersonal deficits are perhaps the most refractory. These deficits refer to long-term difficulties in forming intimate relationships and friendships or in establishing productive work relationships. Such chronic problems cause the patient to lead an isolated, lonely, unsatisfying life, thus precipitating a depression (toward which the patient may be predisposed by virtue of a positive family history, comorbid substance abuse, concomitant medical illness, medications, or other such "biological" factors).

Interpersonal therapy is less

structured and programmatic than cognitive-behavior therapy. It does not offer a set of procedures and out-of-session tasks that can be readily applied to various problems. Rather, interpersonal therapy uses the more traditional psychotherapeutic tools of exploration, encouragement of affect, clarification, communication analysis, use of the therapeutic relationship, and so forth, as well as adjunctive behavior change techniques.[12]

Both interpersonal therapy and cognitive-behavior therapy share one key attribute: an active, directive therapist. It is not surprising to find the two empirically supported treatments for depression sharing this high level of therapist activity. Depressed patients typically need structure and encouragement; passivity and withdrawal from other persons or activities are common patterns of depressed individuals. Moreover, both treatment approaches assume a realistic, problem-centered, therapist-patient relationship; the therapist-patient relationship only is discussed in treatment if it interferes with the problem-solving emphasis of treatment. These action-oriented approaches differ from other psychotherapeutic techniques where discussion of the therapist-patient relationship is central to the treatment.

SUICIDE POTENTIAL

If depression is the common cold of psychiatric and psychological practice, the only significant cause of mortality is suicide. By virtue of their disorder, depressed patients are at greater risk for suicide than most other types of patients. The primary care physician who suspects a diagnosis of depression in a patient, therefore, should take particular care to question the patient in detail regarding suicide and suicide potential.[19] Historical or current indicators of suicidal potential are poor daily functioning, an unstable lifestyle, a history of coping poorly with crises, social isolation, prior psychiatric history, a family history of suicide, serious medical history, geriatric age range, and past suicide attempts.[19] Psychological risk factors include: recent losses, high levels of depression or anxiety, history of hostility toward self or others, acute feelings of hopelessness, cognitive disorientation, and a history of drug or alcohol abuse.[19,20] The physician should be particularly alert to any signs of immediate plans or final arrangements for suicide, such as the giving away of possessions, taking large doses of medication, or purchasing a firearm.

PHARMACOLOGICAL MANAGEMENT

Over the past 30 years, a wide variety of pharmacologic agents of several different classes has become available for the pharmacologic treatment or management of depression and related disorders.

Tricyclic Compounds. Until recently, the mainstay among antidepressant medications were the tricyclic antidepressants. First developed in the 1950s and the 1960s, the tricyclic antidepressants traditionally have been used for patients who met DSM-III-R criteria for "major depression," or "endogenous depression" with the emphasis on so-called severe "biological," "vegetative," "somatic," or "neurovegetative" symptoms of depression: sleep disturbances, physiologic disturbances, e.g. constipation, diminished energy levels, anhedonia, psychomotor retardation, anorexia, and weight loss.[21] Many believe in the validity of Cole's statement, "There is no clear, rational, and useful basis for choosing one agent over another in a drug-free, depressed patient meeting DSM-III-R criteria for major depressive disorder."[22] Some practical guidelines for choosing a particular tricyclic or other cyclic antidepressants for a particular patient, though, include: using a tricyclic that has worked well previously; using an "activating" tricyclic, e.g. desipramine, protriptyline, in patients with lethargy, withdrawal, lack of energy (so-called "apathetic depression"), and using a more sedating antidepressant (amitriptyline or imipramine) in patients with prominent anxiety, worry, tension, handwringing (so-called "agitated depression"); and avoiding an antidepressant associated with specific undesired side effects, e.g. postural hypotension from amitriptyline, i.e. nortriptyline. A comprehensive summary of these can be found in Richelson's work.[23]

The traditional, undesirable side effects of all of the first-generation tricyclic antidepressants include cardiotoxicity (rhythm disturbances, uncomfortable tachycardia, hypotension, and palpitations); peripheral anticholinergic effects (dry mouth, partial urinary retention, and constipation); and sedation (amitriptyline, imipramine, and doxepin). Given these side effects, a reasonable approach to initiating and maintaining drug treatment with these agents includes starting with a low first dose of an antidepressant in the evening, and observing for one to two weeks for indications of improvement. Sleep disturbances often respond quickly, although improvements in mood and affect generally take two to four weeks. If improvement is not forthcoming, blood levels of the antidepressant may be obtained to determine drug metabolism and/or patient compliance with the medication. However, these tricyclic blood levels tend to be variable among patients, and probably are most useful in evaluating patient compliance with the prescribed medication.[22] If peripheral anticholinergic effects produce dry mouth (with an otherwise good antidepressant response), this can be managed by drinking copious amounts of water and/or by sucking hard candy. If more troublesome

peripheral anticholinergic side effects occur, such as urinary retention or constipation, the addition of cholinergic medication, such as bethanechol (25 or 50 mg, three to four times per day) can block the peripheral anticholinergic effects of the tricyclic, and permit patients to tolerate such side effects. However, if these problems continue to threaten patient compliance and do not produce good antidepressant results, consideration should be given to the use of a different type of cyclic antidepressant, a different class of antidepressants altogether, referral to a psychiatrist, or a combination of these considerations.

Depression can be diagnosed and managed effectively. The informed physician should know the two therapeutic approaches to treat depression: cognitive-behavior therapy and interpersonal therapy.

Other cyclic compounds. Historically, the other ("heterocyclic," or "atypical") cyclic compounds were developed to provide alternatives to the cardiotoxic and peripheral anticholinergic side effects of the earlier tricyclic antidepressants. As such, they can be useful in situations where tricyclics cannot be used or have been unsuccessful, or as first-line antidepressant drugs.

Trimipramine has been described as particularly useful with the elderly, as unlikely to cause hypotension, and as a good hypnotic.[24] Clorimipramine, or clomipramine approved by the Food and Drug Administration (FDA) in the United States and marketed as Anafranil®, has been used abroad for a number of years as an antidepressant with a similar pharmacologic profile as imipramine, and as an anti-obsessive agent. Its current FDA approval is for the treatment of obsessive-compulsive disorders.[25] Amoxapine is a metabolite of loxapine (an antipsychotic or neuroleptic agent) and is pharmacologically different from other tricyclic compounds in its liability potential for neuroleptic-induced movement disorders (Parkinsonism or akathisia acutely, or tardive dyskinesia chronically). Patients to be maintained on amoxapine for over two months should be informed about this potential risk.[26] Maprotiline, a "tetracyclic" antidepressant, may have a better cardiotoxicity profile than other tricyclics, and may be indicated for patients with known ischemic heart disease or congestive heart failure.[27] Its main drawback, however, is its slightly increased risk of neurogenic seizures, which can be managed conservatively, by following the *Physicians' Desk Reference*, but which risk should be communicated to patients on maproline.[22]

Several new "heterocyclic" compounds have achieved considerable use recently: trazadone, fluoxetine, and bupropion. Trazadone, a mixed serotonin-selective, nontricyclic antidepressant, is sedating, lacking in peripheral anticholinergic and hypotensive side effects, and has a very safe toxicologic profile in overdose. In our experience, it is a useful first-line agent for patients with agitated depression and sleep disturbances; the rare (but highly publicized) side effect of priapism in males[29] should be communicated to male patients to be maintained on trazadone.

Fluoxetine, a long-acting serotonin-selective, nontricyclic antidepressant, was FDA approved in 1987, and initially received a great initial popularity and use.[30] However, for legal and sociologic reasons its popularity declined,[31] despite its FDA approval and range of clinical uses, including eating disorders and obsessive-compulsive disorders.[32] As an antidepressant, it can be considered activating, i.e. nonsedating, may be associated with nervousness and insomnia (and, therefore, should not be taken at night), and does not apparently exhibit significant peripheral anticholinergic or cardiotoxic side effects. However, taken in combination with other serotonin-selective psychoactive compounds, e.g. L tryptophan and buspirone, "serotonin excess syndromes,"[33] characterized by flushing, lightheadedness, anxiety, aggressivity, and other symptomatology have been described; such combinations generally should be avoided in primary care practice.

Bupropion, a unicyclic antidepressant, is a partial biogenic amine (norepinephrine and serotonin) re-uptake inhibitor, and a partial dopamine re-uptake inhibitor; it does not exhibit clinically significant peripheral anticholinergic effects, nor does it have obvious cardiovascular effects. After reports of seizures in the late 1980s, bupropion was withheld from use in the United States until 1990; patients should be informed about this particular side effect, particularly those at risk for seizures.

Two drugs not considered by pharmacologic class to be antidepressants need to be described due to their presumed antidepressant effects. The first, alprazolam, is a type of benzodiazepine anxiolytic and antidepressant reported to be efficacious in mixed depression-anxiety syndromes.[22] While these mixed properties may be useful for some patients, the benzodiazepines as a class of drugs are anxiolytics, and may

worsen depression, as already described. The physician should be aware of these potential conflicting actions in prescribing this medication. The second, buspirone, is a nonbenzodiazepine anxiolytic, which appears to have anxiolytic properties in low doses (up to 30 mg per day) and antidepressant properties in high doses (greater than 60 mg per day). The mechanism for this bimodal property is limited with the "serotonin spectrum" of behaviors, which suggests that excessive amounts of serotonergic medications could result in "serotonin excess syndrome."[33]

Monoamine oxidase inhibitors (MAOIs). Currently available MAOIs are isocarboxazid, phenelzine, and tranylcypromine, all of which have similar clinical indications, side effect profiles, and dose ranges. Traditionally, patients presenting with atypical depression (defined as including such atypical depressive symptoms as initial insomnia, overeating, excessive sleeping, anxiety, and phobic symptoms, and the lack of endogenous depressive, or vegetative symptoms) are said to respond better to initial treatment of their depression with MAOIs than to tricyclic antidepressants. However, reviews of controlled studies that have examined this conventional wisdom do not confirm this differential effect of MAOIs in treating atypical depression.[34] Rather, the side effect profile of MAOIs—including orthostatic hypotension, weight gain, occasional sexual dysfunction, and the need for patients taking MAOIs to avoid foods containing tyramine (cheeses, chicken livers, red wine, and yogurt) in order to avoid a hypertensive, or pressor crisis—makes it impractical for the primary care physician to manage depressed patients with this class of antidepressants. If the physician finds that a prescribed tricyclic or other cyclic antidepressant, taken as prescribed, in adequate doses is ineffective, our recommendation is to try a different class of cyclic antidepressant, rather than going to MAOIs. If the physician does believe that a trial of MAOIs is indicated, we feel that the patient should be referred to a psychiatrist for further evaluation before undertaking that trial.

CONCLUSION

Depression, a common psychiatric disorder in the general population and in medical practice, can be diagnosed and managed effectively by the primary care physician, often in tandem with the appropriate mental health professional. From our experience and a review of the literature, we have presented an overview of current diagnostic and therapeutic approaches to depression, including suicide assessment. We have emphasized empirically based psychotherapeutic techniques (cognitive behavioral therapy and interpersonal therapy) and pharmacologic management. ■

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Dr. Witt is a partner in Associates in Psychological Services, Somerville, a licensed clinical psychologist, and clinical assistant professor at UMDNJ-Robert Wood Johnson Medical School, New Brunswick. Dr. Greenfield is a managing partner in Brown and Greenfield, Millburn, and is with the Department of Psychiatry, Albert Einstein College of Medicine/Montefiore Medical Center, New York. Dr. Brown is a managing partner in Brown and Greenfield, and is an attending psychiatrist at Elizabeth General Medical Center and at Saint Barnabas Medical Center, Livingston. Address reprint requests to Dr. Witt, 25 North Doughty Avenue, Somerville, NJ 08876.

Federal PRO Program Undergoing Fundamental Transformation

David I. Kingsley, MD
Alexander E. Rodi, Sr, DO

The PRO of New Jersey, Inc. is committed to the ideal of a localized peer review process—one that is based on the belief that New Jersey physicians are best suited to assess the work of their peers. The concept of a local peer review remains absolutely essential.

A fundamental transformation of the federal review program has been initiated by the Health Care Financing Administration (HCFA). The ultimate goal of this transformation is to enlist physicians, providers, and peer review organizations (PROs) in a collaborative effort to improve the mainstream of care provided to Medicare patients.

The Peer Review Organization of New Jersey, Inc. (The PRO) supports HCFA's intent to move the Medicare review process away from evaluating individual clinical encounters and toward providing the health care community with meaningful information on patterns of care and outcome analysis.

HCFA's original plan was to institute its new review methodology—the Health Care Quality Improvement Initiative (HCQII)—with the Fourth Scope of Work for the Medicare Program. In New Jersey, the Fourth Scope was slated to begin on December 1, 1991. In an effort to refine its new process, HCFA has decided to delay implementation of the Fourth Scope until mid-1993. As a result, The PRO and several other PROs due for contract renewals, have received extensions of the current contracts.

Once the Fourth Scope goes into effect, HCFA will randomly select, for PRO review, medical records for inpatient stays for a percentage of the Medicare population each year. At the present time, the specific volume has not been determined. It is important to note that HCQII has not been expanded to include review of care provided in settings other than acute care facilities. Therefore, PROs will continue to review care provided in other settings, e.g. ambulatory surgery centers, home health agencies, skilled nursing facilities, in accordance with the traditional methodology.

A portion of HCQII currently is being piloted by six PROs and is undergoing constant refinement. In an effort to ensure maximum effectiveness for the new initiative, HCFA has been working closely with physicians, providers, and consumers as well as PROs, to perfect the review methods. In addition, HCFA successfully is seeking ways to incorporate consensus development into its screening and review process by including guidelines developed by medical societies and the Agency for Health Care Policy and Research.

The implementation of HCQII will shift the focus of PROs to professional review of patterns and outcomes of care, coordination, and education of the provider and consumer communities, physician review of cases identified through patient care algorithms, and nurse and physician review of mandatory review categories.

The principal components of HCQII are the Uniform Clinical Data Set (UCDS) and the Patient Care Algorithm System (PCAS). UCDS, a software program developed by a team of research clinicians funded by HCFA, is designed for use by nurses who perform initial screening of all medical records selected for PRO review. The goal of UCDS is twofold: to bring a greater consistency and uniformity to the initial screening process and to create a substantial database by collecting three categories of patient data: risk factors, procedures performed, and outcome information.

PCAS is a set of clinical algorithms that apply decision rules to identify possible deviations from standards of care. The algorithms serve two purposes: screening cases for medical review and profiling care. The initial HCFA algorithms were reviewed by consultants and are being evaluated by panels including a workgroup of the American Medical Association. Further re-

Table. *Abbreviations.*

HCFA	= Health Care Financing Administration
HCQII	= Health Care Quality Improvement Initiative
PCAS	= Patient Care Algorithm System
PRO	= Peer Review Organization
UCDS	= Uniform Clinical Data Set

finements will result from ongoing UCDS data analysis and special projects.

The ultimate success of HCFA's new initiative depends upon the ability of PROs to analyze the information collected and to then feed it back to the health care community. Consequently, PROs throughout the country are establishing vital links to academic and medical research institutions. The PRO is in the forefront among PROs nationwide in data collection and analysis.

The PRO is looking forward to the challenges ahead. The PRO is pleased that HCFA is directing its many resources toward developing a more constructive and collegial federal review process. In fact, HCFA already has taken steps in this direction. PROs now are required to provide the involved physician or facility with a reasonable opportunity to enter into and complete a corrective action plan before submitting a sanction recommendation to the Office of the Inspector General.

The PRO always has been and always will be committed to the ideal of a localized peer review process—one that is based on the belief that New Jersey physicians are best suited to assess the work of their peers. At this crucial phase, this concept of local peer review remains absolutely essential. ■

Dr. Kingsley is president of The PRO of New Jersey, Inc. Dr. Rodi a member of the Board of Trustrees of The PRO of New Jersey, Inc. The paper was submitted and accepted in March 1992. Address reprint requests to Dr. Kingsley, The PRO of New Jersey, Inc., East Brunswick, NJ.

DOCTORS' NOTEBOOK

TRUSTEES' MINUTES

A regular meeting of the Board of Trustees was held on March 15, 1992, at the executive offices in Lawrenceville. Detailed minutes are on file with the secretary of your county society. A summary of significant actions follows.

President's Report. Reported the highlights of the AMA Leadership Conference, including the health reform legislation report; AMA's ten congressional priorities (health care reform, Medicare, anti-hassle initiatives, HIV/AIDS challenges, higher education rewrite concerning student loans and accreditation, physician ownership/self-referral, fetal tissue research, gag rule elimination, campaign finances, and international medical school graduate programs); OSHA regulations; and the leadership partnership symposium. Announced AMA delegation allocation remains at ten delegates; Karl T. Franzoni, MD, will be the Speaker and Walter J. Kahn, MD, will be the Vice-Speaker at the MSNJ Annual Meeting; and Mohan Makhija, MD, was named Speaker for the American College of Nuclear Physicians House of Delegates.

Executive Director's Report.

1. Legislation. Noted the following: MSNJ has testified in support of Hospital Capital Improvement Cap, A-844, sponsored by Assemblyman Frelinghuysen, aimed at removal of the hospital capital improvement cap; MSNJ has provided testimony in support of S-413 that would add legislators to the State Health Planning Board; MSNJ has supported legislation to alter the Health Care Administration Board composition to include members of the Legislature (S-450); MSNJ has testified in active support of legislation to delay the implementation date of the State Health Plan to January 1993.

2. Stewart/Copeland versus Sullivan. Noted comments on this class action suit brought against Medicare by Lois J. Copeland, MD, and five of her patients, focusing on the issue of extra-contractual rights by Medicare Part B subscribers (see Open Forum section).

Specialty Reports. Received reports from Stanley S. Bergen, Jr, MD, University of Medicine and Dentistry; Louis P. Scibetta, New Jersey Hospital Association; Jean Taboada, MSNJ Auxiliary; and Gerald Shapiro, MD, Academy of Medicine of New Jersey.

Committee on Long-Range Planning and Development. Approved the following resolution:

That the Board of Trustees set up a mechanism to categorize and review all the policies of the Society and make them part of the policy manual; then evaluate each incoming resolution to the House of Delegates in terms of its conformance with the policy manual.

Referred the following recommendation back to the Committee on Long-Range Planning and Development for further clarification and report to the Board; the Speaker and Vice-Speaker will be invited to attend the meeting when this item is considered to assist in the development of the procedure for reviewing and evaluting resolutions adopted by the House:

That the Board of Trustees authorize the appointment of a committee of the House to evaluate, on an annual basis, the previous years' resolutions of the House, and report to the House on the results of its efforts.

Committee on Annual Meeting. Noted the following items of interest concerning the Annual Meeting: Atlantic City casino hotels must levy a $2 per room, per night use charge as legislated by the state; Daniel H. Johnson, Jr, MD, Speaker of the AMA House of Delegates, will address the MSNJ House of Delegates; Thomas R. Reardon, MD, AMA Trustee, and member of the Congressional Physicians Payment Review Commission, and Assemblywoman Marge Roukema are speakers for the Sunday program, "The Future of American Health Care"; Edward C. Bradley, SJ, MD, special counsellor, Thomas Jefferson University, and attending physician, Thomas Jefferson University Hospital, will conduct the prayer breakfast meeting, "Death with Dignity"; Congressman Robert G. Torricelli will address a JEMPAC political forum on national health issues; and comedian Hal Roach will be featured on the program entitled, "Irish Night," to celebrate Dr. Ryan's inauguration.

Committee on Membership Services. Approved the following:

That MSNJ endorse the Program for International Medical Graduates Practicing Medicine in the United States proposed by Volpe & Associates, as an additional service to the membership.

That MSNJ endorse the Professional Services Accounts (PSA) Program, administered by MBNA America as an additional service to the Society's membership.

That MSNJ endorse the Money Market and Certification of Deposit Program, administered by MBNA America as an additional service to MSNJ's membership.

New Business.

Special Committee on AIDS. Authorized that a Special Commitee on AIDS under the auspices of the Council on Public Health replace the Task Force on AIDS; the president was authorized to appoint the chairman and members of the committee.

Open Forum. Introduced Lois J. Copeland, MD, and provided an update on the class action lawsuit she has initiated with five of her patients. Unanimously approved the motion made by Dr. Keeler calling for MSNJ to form a freedom of choice fund, requesting voluntary contributions from MSNJ to help defray the cost of the Stewart/Copeland versus Sullivan lawsuit; defeated Dr. Keeler's second motion calling for *NEW JERSEY MEDICINE* to devote an entire issue to the Stewart/Copeland versus Sullivan lawsuit and the Medicare problems that provoked it. Also, voted to refer to the Council on Legislation and the Council on Public Relations for consideration, a mechanism to support and to implement the actions approved by the Board. □

MSNJ AUXILIARY

"Choice, Not Chances," the Auxiliary's teen health forum held in March at Medical Society of New Jersey (MSNJ) headquarters, was attended by 400 students and teachers from 30 New Jersey schools.

Keynote speaker, Mr. Michael Green, president of Collegiate Consultants on Drugs and Alcohol, spoke on "Kicks, Kegs, and the Classroom." Mr. Green related his experiences of alcoholism while in college and the devastating effect drinking had on his health and personal life. As an all-American athlete and co-captain of his college football team, Mr. Green found many reasons and occasions to celebrate by getting drunk: before and after examinations, graduation, senior days, homecoming, Memorial Day, Labor Day, back to school, end of school, post-football games, Super Bowl Sunday, St. Patrick's Day, NCAA playoffs, spring break, any holiday, breaking up with a girlfriend, getting back together with a girlfriend, and Thursday, Friday, and Saturday nights. In all, Mr. Green was getting drunk 156 days a year! At age 22, he was an alcoholic.

Sober for four years now, Mr. Green warned students how easy it is to get involved in a drinking pattern. He urged the young people to take charge of their lives and develop a sense of individual responsibility. He ended saying that it is acting socially stupid to think becoming an alcoholic never will happen to you. It can happen and will happen if you do not make the right choices.

Following the keynote address, participants attended their choice of three out of eight breakout sessions presented by state physicians and health care workers: "Overuse Injuries in Sports" by Vincent McInerney, MD, professor and chairman, Department of Orthopaedics and director, Sports Medicine, Seton Hall School of Graduate Medical Education; "Dealing with Feelings" by Reinaldo Alvarez, MD, and Camille Dullaghen, RN; "Food Fright: The Daily Battle To Be Thin" by Jan Janosik, Villanova University; "Problems with Alcohol and Dating" by Phyllis Knighten, YWCA, Trenton; "Sex Games of the 90s, Do You Dare To Play?" by Alan Kreiger, MD, and Marlan Schwartz, MD; "A Teen's Guide to Good Nutrition and Exercise" by Poonan Batra, RD, St. Elizabeth Hospital; "Be Wise When You Drive" by Trooper Tim O'Riordan, New Jersey State Police; "Adolescent Substance Abuse: Crossing Over the Line" by Douglas Teichert, program administrator for Adolescent Services, Fair Oaks Hospital, Summit; and "Sun, Zits, and Beautiful Skin" by Emanuel Ruflik, MD, clinical associate professor, UMDNJ, Cancer Foundation Medical Council. □

Marion H. Geib

UMDNJ NOTES

Doctors Office Center opens at Newark campus. The $55 million UMDNJ-New Jersey Medical School Doctors Office Center on the Newark campus of UMDNJ opened its doors to patients, the climax of over a decade of planning. The eight-level, 154,000-square foot structure is the new home of the UMDNJ-New Jersey Medical School faculty practice services, where academic physicians and dentists now provide an extensive range of health care services that encompass virtually every aspect of the health sciences, including patient care, research, and diverse educational programs.

UMDNJ president supports Governor Florio's proposed budget. I have announced my support of Governor Jim Florio's proposed 1993 budget, which includes $1.061 billion for higher education and urges a cap on tuition increases at 4.5 percent. The following letter to the editor has appeared in New Jersey newspapers:

"The governor recognizes the success story of higher education and its importance to New Jersey's economy. He has found a unique way to improve higher education while minimizing tuition increases and making education affordable and accessible to poor and middle-income families in New Jersey. For medical and dental students, minimum tuition increases are imperative. UMDNJ medical and dental students already pay the nation's fourth highest in-state public school tuition—$11,053. Additional tuition hikes over 4.5 percent would significantly add to the ex-

traordinary financial debt already carried by UMDNJ medical and dental students upon graduation. Their average debt is now a staggering $49,998. With this proposed 4.5 percent cap on tuition, Governor Florio is taking a leadership role in the national debate on the impact of tuition on access to higher education. The governor's proposed cap comes at a time when tuition costs nationwide are skyrocketing. In 1991-1992 nationwide, tuition and fees at public colleges increased by an average of 12 percent; increases in Connecticut and California, for example, were 20 to 40 percent, respectively, while New York's ranged from 16 to 60 percent. New Jersey students also have felt the economic sting of tuition hikes, paying increases that, prior to 1991-1992, outpaced regional and national averages. In 1992, New Jersey tuition increases began to moderate significantly and were generally lower than in previous years but still averaged just under 10 percent at four-year public institutions. The proposed 1993 budget directly benefits all New Jersey families. It not only stabilizes tuition but also provides, through several grants and loans programs, direct assistance to students and their families. Without these programs, many of the state's poor and middle-income families could not afford to send their children to college. We in higher education pledge our continued efforts to manage our resources effectively and creatively in order to maximize the use of state resources and ensure the quality and value of our educational programs."

Reseachers probe zinc link to eye condition. Low zinc levels may put older people at risk for age-related macular degeneration (ARMD). The condition, a gradual destruction of a portion of the retina, affects about 2 percent of those 50 to 65 years old and about 11 percent of those 65 to 75. Damage to the center, or macula, of the retina, does not cause blindness, but the ability to see fine details can be lost. To test the role of zinc as a risk factor, researchers at UMDNJ-New Jersey Medical School will launch a study to compare people who have the condition with those who do not have it. According to Dr. Monique Roy, retina specialist and assistant professor of ophthalmology, it is suspected that older people consume less zinc than younger people and, therefore, may have lower blood levels of zinc. She said that for the first time, zinc will be measured in those with macular degeneration.

Researchers are seeking volunteers who are 55 years or older and who do not have ARMD, to compare them with patients who do have the condition. The two groups will be matched according to sex, socioeconomic status, race, and age. These factors are believed to be potential influences for the development of ARMD. The type of occupation may be a factor because exposure to sunlight may be a risk factor for ARMD. Also, the amount of eye pigmentation may affect the condition.

Study volunteers will receive a comprehensive eye examination, including visual acuity and tests for glaucoma and ARMD. The visit, including the examination, blood test, and diet questionnaire, will take about an hour and is free of charge.

Further information about the study may be obtained by calling 1/201/982-2020.

Exhibit of rare collector's items. A mannequin-like wood and rubber model of a woman used by French medical students in the late 1800s to learn birthing techniques is one of several unique items on display at UMDNJ-George F. Smith Library of the Health Sciences in Newark. Called the Budin-Pinard Obstetrical Teaching Phantom, the model is one of only two in the world. It is among several rare artifacts included in an exhibit, "Collectors and Their Collections." The exhibit is on display through September in the lobby of the library. ☐ Stanley S. Bergen, Jr, MD

PLACEMENT FILE

The following physicians have written to the executive offices of MSNJ seeking information on opportunities for practice in New Jersey. If you are interested in any further information, please contact the physician directly.

Internal Medicine

Glen W. Berger, MD, Cooper River Plaza, Apt. 809 South, Pennsauken, NJ 08109. UMDNJ 1989. Board eligible. Suburban, private practice group. Available July 1992.

Sheryl S. Hertel, MD, 6205 Brogan Pl., St. Louis, MO 63128. St. Louis 1986. Also, pediatrics. Board certified; board eligible (PED). Group. Available.

Tina M. Josephson, MD, 12043 White Cord Way, Columbia, MD 21044. Hahnemann University 1988. Group or partnership. Available July 1992.

Cynthia K. Menack, MD, 3132 Perry Ave., Apt. 2A, Bronx, NY 10467. Mount Sinai 1989. Board eligible. Group practice or medical clinics. Available July 1992.

John Musico, MD, 262 Pine Valley Rd., Dover, DE 19901. St. George 1988. Board eligible. Available.

Pathology

Sarita Khanijo, MD, 1710 NW Calkins, Roseburg, OR 97470. MGM Medical College (India) 1976. Board certified. Group or partnership. Available.

Pulmonary Medicine

Vinod Khanijo, MD, 1710 NW Calkins, Roseburg, OR 97470. Delhi University (India) 1963. Also, critical care. Board certified. Solo. Available July 1992. ☐

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The 8th Annual International Symposium on Acupuncture & Electro-Therapeutics will be held at Columbia University, School of International Affairs, 420 W. 118th St., N.Y. City, during **October 15-18, 1992.**

These meetings are co-sponsored by the International College of Acupuncture & Electro-Therapeutics & its official journal, Acupuncture & Electro-Therapeutics Research, The International Journal (published by Pergamon Press & indexed in 15 major indexing periodicals, including Index Medicus), Heart Disease Research Foundation; NY Pain Center; Electrical Engineering Dept., Manhattan College; Nordic Medical Acupuncture Society (Scandinavia); Schmerz Therapeutische Kolloquium (West Germany); Japan Bi-Digital O-Ring Test Assn.; Accredited toward Acupuncture Certification to practice acupuncture. Eligible for AMA CME Cat. I credit (about 40 credit-hours for the Symposium).

For information on meetings or submission or presentations of papers, contact Symposium Chairman, Prof. Y. Omura, M.D., Sc.D., 800 Riverside Drive (8-I) New York, NY 10032 Tel: (212) 781-6262 (10 am to 10 pm 7 days a week) or (212) 928-0658, Co-chairman, Prof. A.W. Cook, MD (516) 877-1821, or Bro. Michael Losco (212) 920-0162.

CONTINUING EDUCATION

INFECTIOUS DISEASE

June

3 **Identification and Management of Asymptomatic HIV Infection**
12 Noon-1 P.M.—Union Hospital, Union
(AMNJ and NJDOH)

9 **Identification and Management of the HIV Indeterminant Infant**
9:30-10:30 A.M.—MCOSS Nursing Services, Red Bank
(AMNJ and NJDOH)

9 **Identification and Management of the HIV Indeterminant Infant**
8-9 A.M.—Newcomb Medical Center, Vineland
(AMNJ and NJDOH)

19 **Identification and Management of the HIV Indeterminant Infant**
12 Noon-1 P.M.—Medical Center of Ocean County, Point Pleasant
(AMNJ and NJDOH)

July

17 **Identification and Management of Asymptomatic HIV Infection**
9-10 A.M.—St. Francis Medical Center, Trenton
(AMNJ and NJDOH)

MEDICINE

June

3 **Neonatal Problems**
10:30-11:30 A.M.—St. Mary's Hospital, Passaic
(AMNJ)

3 **Endocrinology Monthly Meeting**
6-9 P.M.—Holiday Inn, Newark Airport, Newark
(AMNJ)

3
10 **Endocrinology Grand Rounds**
17 11:30 A.M.-1 P.M.—VA Medical
24 Center, East Orange
(AMNJ)

3
10 **Interhospital Endocrine**
17 **Rounds**
24 3:30-5:30 P.M.—Newark Beth Israel Medical Center, University Hospital, VA Medical Center, and United Hospitals Medical Center
(AMNJ)

5-
6 **Obstetrics/Gynecology**
Trump Plaza and Hotel and Casino, Atlantic City
(NJ Obstetrics and Gynecological Society)

5-
19 **Grand Rounds**
9-10 A.M.—St. Francis Medical Center, Trenton
(St. Francis Medical Center)

10 **Seizure Disorders and Rational Use of Anticonvulsants**
8 A.M.-3:45 P.M.—The Mansion on Main Street, Voorhees
(AMNJ)

10 **Nuclear Medicine**
10:30-11:30 A.M.—St. Mary's Hospital, Passaic
(AMNJ)

12 **Health Promotion for People with Down's Syndrome**
12 Noon-1 P.M.—Centrastate Medical Center, Freehold
(AMNJ)

12-
13 **Annual Meeting: New Jersey Gastroenterological Society and New Jersey Society for Gastrointestinal Endoscopy**
Seasons Resort and Conference Center, Great Gorge
(AMNJ)

15 **Diabetic Retinopathy**
1-2 P.M.—New Lisbon Developmental Center, New Lisbon
(AMNJ)

17 **Neurosurgical Emergencies**
10:30-11:30 A.M.—St. Mary's Hospital, Passaic
(AMNJ)

24 **Geriatric Roving Symposia**
2:30-3:30 P.M.—Trenton Psychiatric Hospital, Trenton
(AMNJ)

24 **Prevention of LEA**
11:30 A.M.-12:30 P.M.—Hamilton Hospital, Hamilton
(AMNJ)

25-26 **Breaking the Chain of Violence**
9 A.M—UMDNJ-Robert Wood Johnson Medical School, New Brunswick
(UMDNJ)

ONCOLOGY AND RADIATION ONCOLOGY

June

3 **Bone Marrow Transplantation**
6-10 P.M.—Hyatt Regency, New Brunswick
(AMNJ)

18 **Tumor Board Conference**
12:15-1:15 P.M.—Mercer Medical Center, Trenton
(Mercer Medical Center)

PSYCHIATRY

June

3 **Altered States: Dreams, Sleep, and Dissociation**
All day—Carrier Foundation, Belle Mead
(Carrier Foundation)

17 **Psychiatry Medication Interactions**
2:30-3:30 P.M.—Ancora Psychiatric Hospital, Hammonton
(AMNJ)

25-26 **Breaking the Chain of Violence**
9 A.M.—UMDNJ-Robert Wood Johnson Medical School, New Brunswick
(UMDNJ)



IN MEMORIAM

STEWART F. ALEXANDER

The former president of our Bergen County component, Stewart F. Alexander, MD, died on December 6, 1991. Dr. Alexander was 77 years old. Dr. Alexander was born on August 30, 1914, in Park Ridge. He was awarded a medical degree from Columbia University College of Physicians & Surgeons, New York, in 1937. In 1939, Dr. Alexander received his New Jersey medical license. Dr. Alexander served in the United States Army from 1940 to 1945; he helped to identify and to treat soldiers exposed to mustard gas. Following his military service, Dr. Alexander practiced in Park Ridge, specializing in internal medicine and cardiology. Dr. Alexander was director of medicine at Bergen Pines County Hospital, Paramus, for 18 years, where he helped to build the medical and education divisions. During his medical career, Dr. Alexander was affiliated with Bellevue Hospital, New York; Hackensack Hospital; and Pascack Hospital, Westwood. Dr. Alexander was a diplomate of the American Board of Internal Medicine; a member of the American Medical Association; and a fellow of the American College of Physicians, of the American College of Angiology, of the American College of Cardiology, and of the Royal Society of Medicine. In 1987, the New Jersey Chapter of the American College of Physicians awarded Dr. Alexander the Laureate Award, for his distinguished career accomplishments. He also served as the director of the Premedical Summer Program at Pascack Valley Hospital.

ANGELO M. GNASSI

At the grand age of 92, Angelo M. Gnassi, MD, of Allenhurst, died on November 26, 1991. Born in 1899 in Italy, Dr. Gnassi attended the University of Vermont College of Medicine, Burlington, and graduated in 1930. A pathologist, Dr. Gnassi was chief pathologist and director of laboratories at Jersey City Medical Center. He was the Hudson County medical examiner from 1969 to 1973; and was professor of pathology at Seton Hall University and at UMDNJ. Dr. Gnassi authored numerous articles on research and developments in pathology. Dr. Gnassi was a member of our Hudson County component and of the American Medical Association, and was affiliated with the former B.S. Pollack Hospital, Jersey City. He served in the Italian Army during World War II, receiving four medals for bravery. Following his military service, Dr. Gnassi was a diplomat for the Italian government, stationed in Germany. Dr. Gnassi formerly resided in Jersey City.

ALBERT H. HELM

A specialist in emergency medicine and industrial and occupational health, Albert Harry Helm, MD, died on October 7, 1991. Dr. Helm was 66 years old. He was born on April 23, 1925, in Camden. After serving in the United States Navy from 1943 to 1946, Dr. Helm was awarded a medical degree from Jefferson Medical College, Philadelphia, in 1950. The following year he received his New Jersey medical license. Dr. Helm maintained an

office in Collingswood. He also was associated with West Jersey Occupational Health Services, Voorhees; West Jersey Hospital in Berlin, Camden, Marlton, and Voorhees; Underwood Memorial Hospital, Woodbury; and Cooper Hospital/University Medical Center, Camden. He was a member of our Camden County component and of the American Medical Association.

NORVAL F. KEMP

Manasquan resident, Norval Foard Kemp, MD, passed away on October 20, 1991, at the age of 75. Dr. Kemp was born on August 12, 1916, in Baltimore, Maryland. After graduating from the University of Maryland School of Medicine, Baltimore, with a medical degree in 1941, Dr. Kemp was a lieutenant commander in the United States Navy from 1943 to 1946 aboard the *USS Sproston*. He received his New Jersey medical license the following year. Dr. Kemp completed an internship at University Hospital of Maryland, Baltimore, and a residency at Jersey City Medical Center. Dr. Kemp was an internist, and maintained a private practice in Jersey City from 1946 to 1969. He was medical administrator at St. Francis Hospital, Jersey City, from 1970 to 1973 and at Raritan Bay Hospital, Perth Amboy division, from 1973 to 1986; affiliated with Christ Hospital, Perth Amboy General Hospital, and Jersey City Medical Center; and clinical associate professor at UMDNJ-New Jersey Medical School, Newark. Dr. Kemp was a member of our Middlesex County and Hudson County components and of the American Medical Association, a diplomate of the American Board of Internal Medicine, a fellow of the American College of Physicians, and president of the New Jersey Society of Hospital Administrators.

BIRUTA LIEPA-JANSEN

General surgeon Biruta Liepa-Jansen, MD, passed away on December 26, 1991. She was born on November 10, 1925, in Latvia. Dr. Liepa-Jansen was awarded a medical degree from the Medical Faculty of Heidelberg, Germany, in 1955. She completed an internship and a residency at Cooper Hospital/University Medical Center, Camden. Dr. Liepa-Jansen received her New Jersey and Virginia medical licenses in 1960 and 1961, respectively. Dr. Liepa-Jansen was on staff at Cooper Hospital/University Medical Center; she was a member of our Camden County component and of the American Medical Association, and a fellow of the American College of Surgeons. Dr. Liepa-Jansen resided in Cherry Hill.

ROBERT G. SALASIN

Former president of our Cape May County component, general surgeon Robert George Salasin, MD, passed away on November 17, 1991. Dr. Salasin was 72 years old. Dr. Salasin was born in Atlantic City, resided in Wildwood, and retired to Lighthouse Point, Florida. He was awarded a medical degree from Jefferson Medical College, Philadelphia, in 1944. The following year, Dr. Salasin received his New Jersey medical license. He served an internship at Atlantic City Hospital and a residency at Brooke Army Medical Center, San Antonio, Texas. Dr. Salasin was chief of surgery at Burdette Tomlin Memorial Hospital, Cape May Court House, and was affiliated with Mercy Hospital, Sea Isle City. He was a fellow of the American College of Surgeons, a member of the American Medical Association, and a diplomate of the American Board of Surgery. Dr. Salasin served in the United States Army Medical Corps reserves from 1944 to 1956.

EDITORIAL CRITERIA

CONTENT

NEW JERSEY MEDICINE is the official organ of the Medical Society of New Jersey. The goals are educational and informational. All material published is copyrighted by the Medical Society of New Jersey.

The educational contents of each issue appear as scientific articles, based on research, original concepts relative to epidemiology of disease, and treatment methodology; case reports; review articles; clinical notes; state of the art reports; and special articles, that include evaluations, policy and position papers, and reviews of nonscientific subjects. Other topics include professional liability commentary; critical narration; medical history; pediatric briefs; nutrition update; and opinions. Editorials are prepared by the editor and by guest contributors on timely and relevant subjects. The Doctors' Notebook section contains organizational and administrative items from the Medical Society of New Jersey and from the community. Letters to the editor and book reviews are welcome and will be published as space permits.

The principal aim in the preparation of a contribution should be relevance to diagnosis and treatment and to the education of patients and professionals. Preference will be given to authors from New Jersey and to out-of-state lecturers submitting a suitable manuscript based on a presentation made to an audience in New Jersey.

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SPECIFICATIONS

Submit two manuscripts that must be typewritten and double spaced on 8½" by 11" paper. Statistical methods used in articles should be identified.

The title page should include the full name, degrees, and affiliations of all authors, and the name and address of the author to whom reprint requests and correspondence should be sent.

The author should submit a 30-word abstract to be used at the beginning of the article.

Tables must be typewritten and double spaced on separate 8½" by 11" sheets, with a title and number. Symbols for units should be confined to column headings, and abbreviations should be kept to a minimum.

Illustrations should be professional quality, black-and-white glossy prints. The name of the author, figure number, and the top of the figure should be noted on a label attached to the back of each illustration. When photographs of patients are used, the subjects should not be identifiable or publication permission, signed by the subject or responsible person, must be included with the photograph. Material taken from other publications must give credit to the source.

Generic names should be used with proprietary names indicated parenthetically or as a footnote with the first use of the generic name. Proprietary names of devices should be indicated by the registration symbol—®.

The summary of the article should not exceed 250 words; it should contain essential facts.

References should not exceed 35 citations except in review articles, and should be cited consecutively by numbers in parentheses at the end of the sentence. The style of *NEW JERSEY MEDICINE* is that of *Index Medicus:*

1. Goldwyn RM: Subcutaneous mastectomy. *NJ MED* 74:1050-1052, 1977.

PUBLICATION POLICY

Receipt of each manuscript will be acknowledged; the paper will be referred to the Editorial Board. Final decision is reserved for the editor. No direct contact between the reviewers and the authors will be permitted.

All communications should be sent to *NEW JERSEY MEDICINE,* MSNJ, 2 Princess Road, Lawrenceville, NJ 08648. □

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Copy deadline: 5th of preceding month; Payment in advance; $5.00 first 25 words, 10¢ each additional. Count as one word all single words, two initials of name, each abbreviation, isolated numbers, groups of numbers, hyphenated words. Count name and address as five words, telephone number as one word, Box No. 000, NEW JERSEY MEDICINE as five words.

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FAMILY PHYSICIAN—Young, solo physician in growing practice seeks associate. Part-time/full time, possibly leading to partnership. Monmouth County. Contact Box No. 430, NEW JERSEY MEDICINE.

FAMILY PHYSICIAN—Sarah, John, Kent, John and I are looking for "doctor right." We practice general medicine in Green Brook, central New Jersey. We have a great practice and reputation. We have a large wonderful staff and are highly rewarded financially. If you are loved and respected by your co-workers, call us for full/part-time. Ed McGinley, M.D., 908-968-8900, 908-277-0466 or John Pilla 908-302-1381.

INTERNIST—Edison, NJ. July opening for Internist in two-person practice. Modern facilities with early partnership. Milton Bronstein, MD, 776 Amboy Avenue, Edison, NJ 08837. 908-738-8000.

PHYSICIAN WANTED—New Jersey Worker's Compensation evaluations for Central and South Jersey areas. Must be Board Certified in F.P., E.R.; or O.M. Contact Box No. 441, NEW JERSEY MEDICINE.

PRIMARY CARE INTERNIST—Seeks Association with another MD to start a New Jersey practice. Contact Box No. 015, NEW JERSEY MEDICINE.

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PEDIATRICIAN—Livingston-Morristown. BC/BE Pediatrician to join two-person suburban practice. Warm, friendly office and patients. Teaching hospital affiliations. Dr. Richard Lander, 203 Hillside Ave., Livingston, NJ 07039. (201) 992-5588.

PRACTICE WANTED—Board Certified Internist looking for attractive medical practice. Contact after 8 P.M. 201-265-7160.

PRACTICE WANTED—Looking for a medical practice from a retiring MD in Morris, Somerset, or Hunterdon County. Please reply to Box No. 014, NEW JERSEY MEDICINE.

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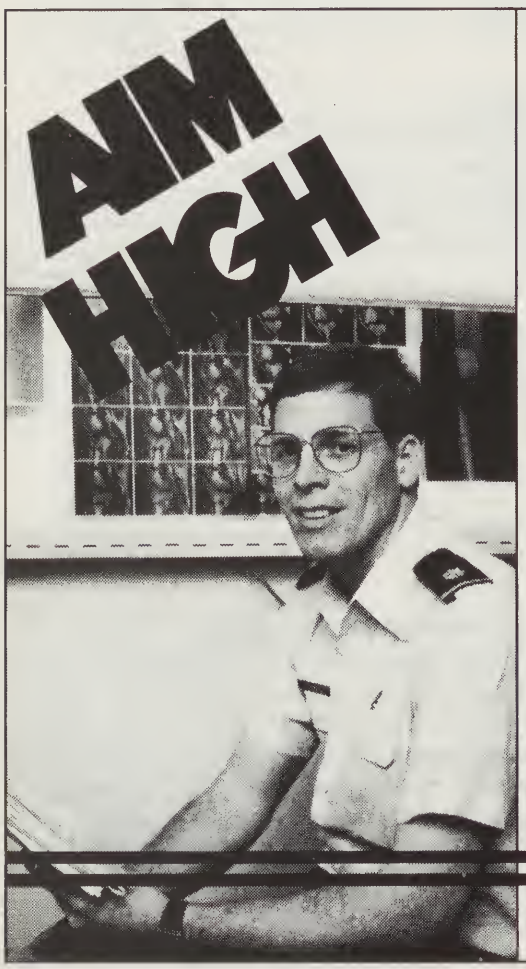
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Newswatch

SBME BUSINESS PRACTICE RULES...

Calling the new business practice rules for New Jersey physicians "the most sweeping and far-reaching enactment of their type in the country," the Medical Society of New Jersey (MSNJ) has asked the State Board of Medical Examiners (SBME) to delay the rules' implementation. In response to litigation, SBME has stayed until July 7 the most controversial rule, which prohibits physicians from charging more than a 10 percent markup on medications, medical goods, and devices.

Summarized in the March 1992 "MSNJ Newsletter," the rules require physicians to have medical policies and procedures. However, these policies do not have to be written, according to an interpretation provided by SBME member Fred M. Jacobs, MD, and Deputy Attorney General Joan D. Gelber at a forum held at MSNJ executive offices in Lawrenceville on April 28, 1992. Examples of medical policies might include which services are offered at a physician's office, how patients' refusals to pay bills are handled, and which procedures require a physician's presence.

A major thrust of the new rules is to permit physicians and other licensed health professionals to own a health facility jointly. Other provisions affect notices on fees, employment

of other practitioners, disclosure of financial interest involving referrals, compensation for referrals, investment returns, and notifying SBME of investments in health facilities.

Ms. Gelber disclosed to the MSNJ forum that one reason for the requirement for policies and procedures is to subvert what she termed the "Eichmann defense," in which employed staff deny any awareness or responsibility for actions of the employing physician. Ms. Gelber also has indicated that hospitals will be expected to review all referrals to their own emergency department by physicians who have exclusive contracts with the hospital. Dr. Jacobs told the MSNJ forum that the concept behind the business practice rules is to assure that the physician-patient relationship does not degenerate into a connection between seller and buyer.

MSNJ MATERIALS ON OSHA RULES...

Policy and procedure manuals covering the federal Occupational Safety and Health Administration's (OSHA) regulations on universal precautions and chemical hazard communications have been developed by MSNJ. Copies of the manuals are available to MSNJ members at a production-and-distribution fee of $20, and to all others, at a fee of $95. Orders and payment may be sent to Marge Bolling, MSNJ, Two Princess Road, Lawrenceville, NJ 08648.

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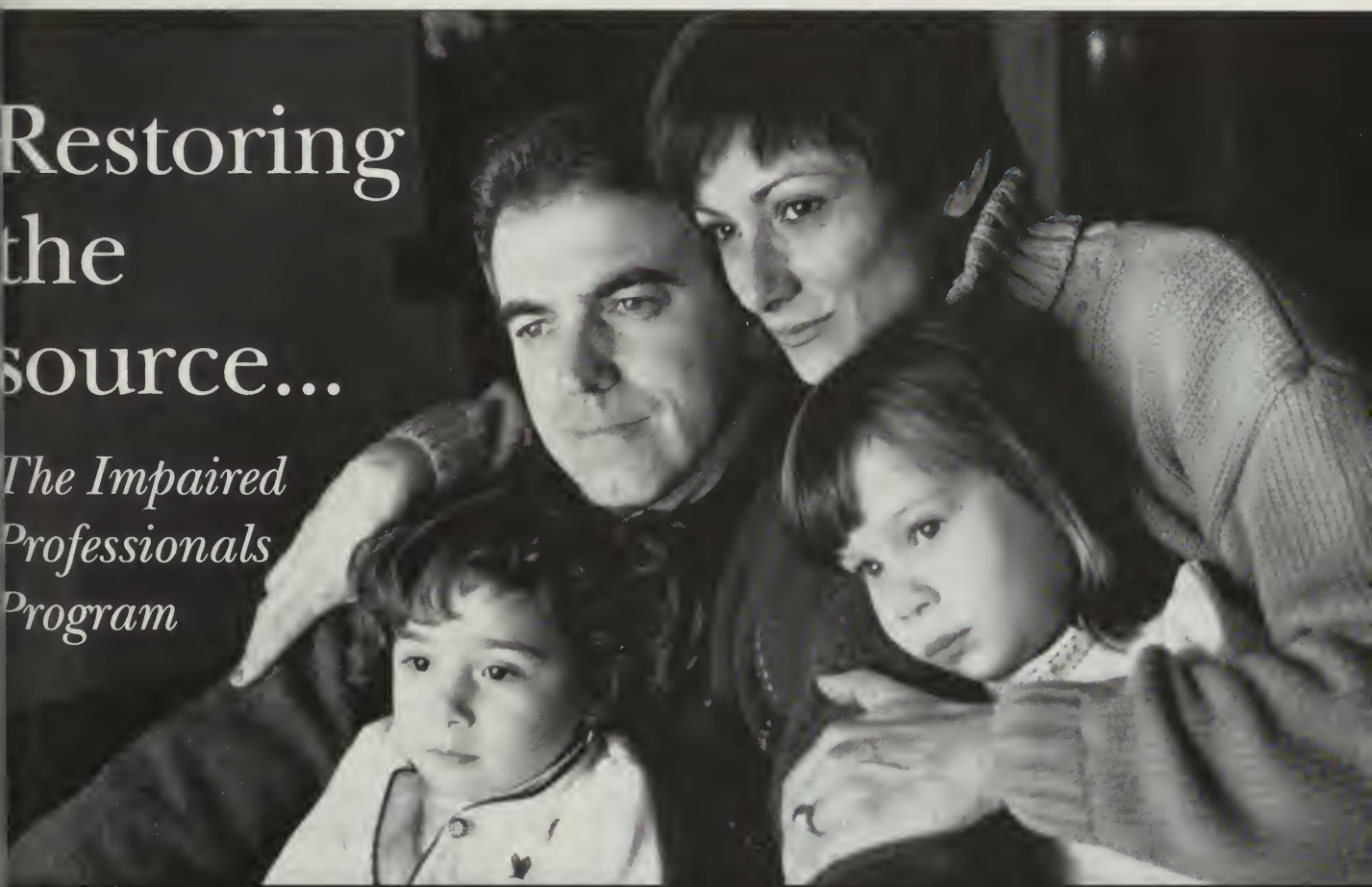
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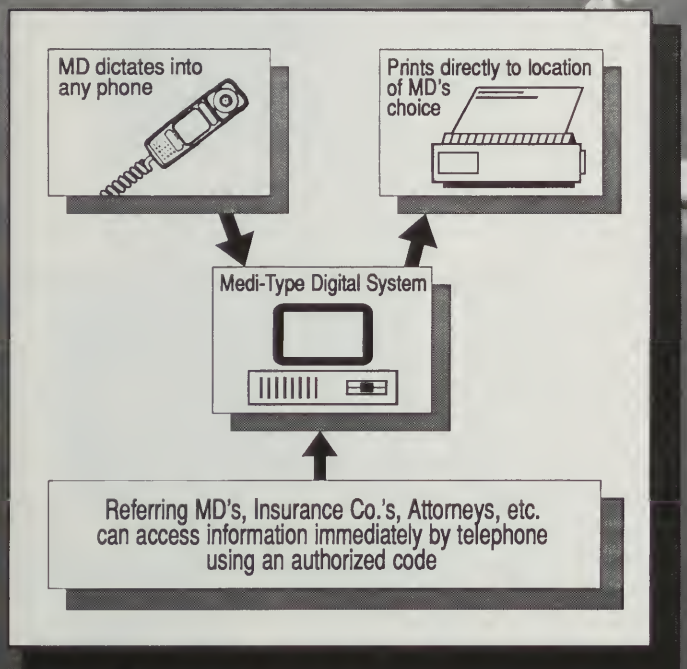
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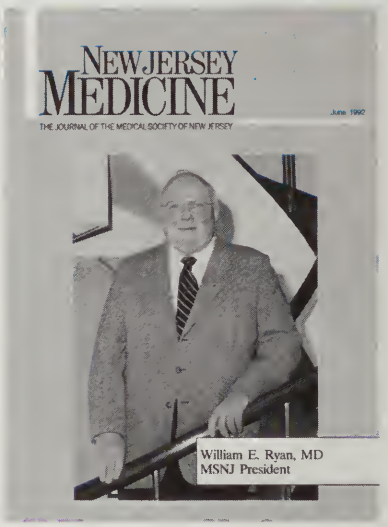
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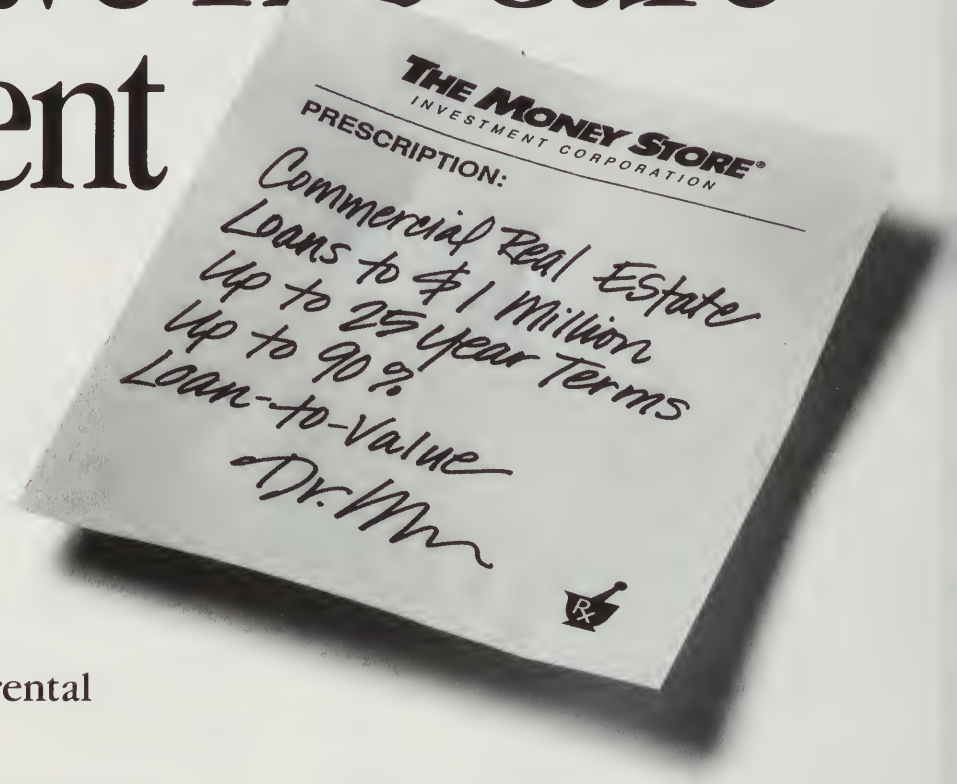
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MSNJ NEWSLETTER

MEDICAL EXAMINERS OPPOSE MANDATORY ASSIGNMENT

On April 8, 1992, the State Board of Medical Examiners (SBME) voted to oppose two mandatory assignment bills in the state Assembly. A-923, which would prohibit all balance billing, was "strongly opposed"; A-926, which would prohibit balance billing of patients below specified income levels, was merely "opposed."

In action on other bills, SBME strongly opposed A-565, which would require parental notification for abortions for minors, and opposed A-588, which would raise the standard of proof on licensure actions taken by the Board to the level of "clear-and-convincing evidence." SBME past-president Michael Grossman, DO, commented that A-588 is a "self-serving bill that would keep bad doctors in practice."

On issues related to HIV testing, SBME strongly opposed S-98, which would permit mandatory testing in certain circumstances, and strongly supported A-924, involving reporting of HIV cases.

NEW MEDICAL DIRECTOR OF SBME

William I. Weiss, MD, a Livingston allergist and former president of the Essex County Medical Society, has been named the first medical director of the State Board of Medical Examiners (SBME). Under the Medical Conduct Reform Act of 1990, the office of medical director and a practitioner review panel were established to assist SBME in its disciplinary activities.

BED CLOSURES DID NOT CUT COSTS

A Massachusetts state legislator who helped spearhead the Dukakis administration's health care program has become a critic of that program.

In an article published in the *Journal of American Health Policy*, Representative John E. McDonough observes that the former governor's "key interest was to delicense empty hospital beds and to close as many hospitals as possible on the theory that capacity shrinkage would reduce costs. The evidence suggests that this theory was wrong." Nevertheless, in our state, the Florio administration continues to press the same strategy, through the proposed State Health Plan. Massachusetts has since reversed its approach and embarked on deregulation.

DR. LEON SMITH RECEIVES AWARD

Public Service Electric and Gas Co. (PSE&G) presented Leon G. Smith, MD, of Essex Fells, with a certificate of appreciation for his participation in the company's Industrial Hygiene Discussion Group, a bimonthly educational session designed to teach employees about new regulatory standards that affect them in the workplace. Dr. Smith is a member of the Editorial Board of *NEW JERSEY MEDICINE* and a member of our Essex County component. Dr. Smith, chief of infectious disease and director of medicine at Saint Michael's Medical Center, Newark, discussed universal precautions as they relate to cardiopulmonary resuscitation and other lifesaving techniques during the program.

DUNSTON AND RIGGS CALL FOR HIV TESTING

In a letter sent in May to all obstetrician-gynecologists who are members of the Medical Society of New Jersey, State Commissioner of Health Frances J. Dunston, MD, MPH, and Joseph A. Riggs, MD, stated that it is "imperative" that "pregnant women be offered HIV testing." The letter advises that all women of childbearing age should receive HIV/AIDS education and counseling on risk reduction. Dr. Dunston also is sending a similar letter to obstetrician-gynecologists who are not MSNJ members.

FIREWORKS EYE-Q TEST

1. Very few people are injured seriously by fireworks. **False.** Almost 10,000 fireworks injuries are reported annually. Of the 1,600 injuries involving the eye, 40 percent result in permanent eye damage.

2. Average fuse burning time for a firework is 15 seconds. **False.** According to the Consumer Product Safety Commission performance standards, retail fireworks must have fuses that burn for 3 to 6 seconds.

3. Hand-held sparklers are safe for children. **False.** Sparklers burn at 1,800°C—almost hot enough to melt gold. Flying pieces striking the eye have caused total blindness.

4. Making your own fireworks is okay, if you know what you are doing or buy an advertised fireworks construction kit. **False.** Mixing and loading chemical powders is very dangerous and can result in explosions that blind or maim users. Pipe bombs made with match heads can exceed the explosive force of a stick of dynamite.

5. Spectators rarely are injured. **False.** In one study, 40 percent of those suffering eye injuries were bystanders.

6. The safest place to enjoy fireworks is at a community-sponsored public display. **True.** Experts recommend that the igniting, detonating, and handling of fireworks be left to professionals.

AMA ADVISORY COUNCIL TO IMGs

Leticia V. DeCastro, MD, was appointed as a member of the American Medical Association (AMA) Advisory Council to International Medical Graduates (IMGs). Here is her report:

The AMA Advisory Council to IMGs hosted a forum for IMGs in Chicago. It was a very well-attended meeting. IMGs representing ethnic organizations, state medical societies, and specialty societies were present. Dr. J. Painter was the luncheon speaker and Dr. James Todd gave the welcome address. Janice Pieper, IMG lobbyist in Washington, DC, spoke on the Solarz-Kennedy Anti-Discrimination Legislation; Norbert Bridde discussed the status of NCVS; and Lynn Harvey detailed the preliminary report on IMGs Attitude Research.

The forum was very productive. There was a feeling of cooperation among those present and an indication of a great necessity to work together to solve the problems of IMGs in the United States. There was a general conclusion that the AMA wants to put an end to discrimination against IMGs and build solid bridges to the different organizations represented.

RYAN TESTIFIES ON NATIONAL HEALTH REFORM

In testimony before the Select Committee on Aging of the U.S. House of Representatives, William E. Ryan, MD, stated on behalf of the Medical Society of New Jersey that "the way to bring

about universal coverage for all Americans is through a coordinated national health care policy, not through a nationalized health care system." In response to suggestions that health care is more efficient in Canada than in the United States, Dr. Ryan noted several situations in which Canadian patients routinely are referred to U.S. hospitals where care is less costly. "It is like the Berlin Wall," Dr. Ryan observed, "they are going in one direction only."

REFERRAL NETWORK FOR CHILDREN IN CRISIS

A National Referral Network for Kids in Crisis has been established. Directed by Wiley House Treatment Centers in Orefield, PA, the network includes listings of thousands of emergency shelters, sexual abuse treatment centers, suicide counseling services, substance abuse clinics, residential and foster care providers, and other diverse health and social services. The network can be reached at 1/800/KIDSAVE.

COVERAGE OF MENTAL HEALTH CARE

Nine New Jersey mental health groups have formed a coalition calling for coverage of treatment of mental illnesses and substance abuse in all federal and state payment plans. Cost-effective screening and after-care services would be included.

The coalition contends that copay, deductible, and cap provisions in insurance plans should be consistent across mental health care and treatment for other health problems. Included in the Coalition for Comprehensive Health Care of New Jersey are the Mental Health Association of New Jersey, based in Montclair, and the New Jersey Psychiatric Association.

VACCINE BROCHURES

Physicians are squirming under new federal requirements to provide detailed brochures to patients and families whenever any of six vaccines is administered. Covered are immunizations against polio, measles, DTP, mumps, rubella, and tetanus (namely, DTP, DT, Td, OPV, IPV, and MMR).

Physicians further are required to record each immunization with date, manufacturer, lot number of the vaccine, and name, address, and title of the person administering the vaccine. They also must report adverse events to particular agencies, depending on whether the vaccine was purchased publicly or privately.

The requirements, which may impose costs of two dollars or more per vaccination, result from concerns over manufacturer liability, which affects vaccine supply. The Medical Society of New Jersey is considering ways to assist physicians in obtaining batches of the prescribed brochures. □

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These studies allow *free* treatment with Sertraline, a new selective Serotonin Reuptake Inhibitor. Sertraline is now FDA approved for treatment of depression under the trade name, Zoloft, and is being studied for the possible use in the treatment of OCD, panic and obesity.

DEPRESSION (TRICYCLIC NON-RESPONDER STUDY):
One study allows patients who have not responded to adequate doses of Elavil, Sinequan, Tofranil, Norpramin or Pamelor for four weeks, to receive *free* treatment with Wellbutrin for eight weeks. Other new generation research medication studies for patients not on tricyclics are also available.

ALZHEIMER'S DISEASE:
Both THA and and another investigational drug are cholinesterase inhibitors. Participants will receive *free* medical care, cat scans, evaluations and medications. In some cases, the patient will be allowed to continue on these medications after the study is completed.

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PROFESSIONAL LIABILITY

READERS' SURVEY

One year ago we reformated the "Professional Liability" commentary in *NEW JERSEY MEDICINE* to provide more information about New Jersey cases, more of our interpretation of events, and broader coverage of health policy. We now seek your view of the wisdom of these changes. To help us best respond to your needs, please complete the questionnaire at the end of this month's commentary. We appreciate your participation.

AIDS ISSUES

OSHA regulations. Many organizations are offering informational products to physicians anxious to comply with new federal requirements for universal precautions in office practices. The requirements were issued by the Occupational Safety and Health Administration (OSHA), which also has inspection and enforcement capabilities. The requirements involve extensive paperwork, equipment, and training—despite the relative paucity of cases of HIV transmission between patients and health professionals to date.

The Medical Society of New Jersey (MSNJ) has developed policy and procedure manuals for physicians' offices on universal precautions and on OSHA rules involving other hazards. For information, call MSNJ at 1/609/896-1766.

Reduction of AIDS benefit upheld. Federal law permits employers to reduce lifetime benefits to employees with AIDS, under a ruling issued by the U.S. Fifth Circuit Court of Appeals. Affirming a district court decision from the Southern District of Texas, the appeals court held that an employer could reduce compensation of AIDS-afflicted employees from $1 million to $5,000 after learning that an employee did qualify for the benefit. The case involved ERISA, the federal statute that sets minimum requirements on employee benefit plans. ERISA, said the court, permits employers to change their benefits if a summary plan description reserves to the employer the right to make changes. Moreover, ERISA does not mandate that certain illnesses be covered, the court added.

MALPRACTICE VERDICTS

Failure to diagnose MI. A defendant emergency physician and hospital failed to persuade a New Jersey jury that a delay in diagnosing a myocardial infarction (MI) caused no additional heart damage. In a trial for damages and for a determination of how much additional injury would have been avoided by earlier diagnosis, the jury found that 70 percent of the total injury resulting from the heart damage was attributable to the physician's negligence in failing to order an electrocardiogram (EKG) or to admit the patient to the hospital when the patient presented with chest pain. The next day the patient visited a family physician who took an EKG and admitted him to another hospital.

An earlier trial had resulted in a negligence verdict and a jury finding that all of the injury could have been avoided. The latter finding was overturned by the judge as clearly erroneous, occasioning the second, limited trial.

In the latter trial, a cardiologist testified on the plaintiff's behalf that the delay caused the effects of the infarct to be extended to other areas of the heart. The expert further asserted that the delay led to an aneurysm in the heart muscle that posed a risk of sudden death. A defense expert disputed the former claim and attributed the aneurysm to a six-hour period that preceded the visit to the emergency department. The risk of sudden death and fear of impending doom were emphasized by the plaintiff.

The jury's award of $500,000 for pain and suffering during the day before admission to the other hospital was reduced by the judge to $100,000. A figure of $2 million for the remaining, total injury was molded in accord with the 70 percent finding and let stand. In instructions to the jury, the court invested the defense with the burden of proving that the extended harm was not caused by the delay.

Perforations of uterus. Could two uterine perforations have resulted in the absence of negligence? Yes, said a New Jersey jury, which also found no merit to the plaintiff's claim that medication to control bleeding should have been used before the dilatation and curettage were performed.

The bleeding came in the wake of an uncomplicated delivery of the patient's first child. The defendant used a probe, known as a "sound," to locate the uterine wall and then used a curette. According to the plaintiff's expert, the use of the curette after a perforation was suspected was

negligent, and a laparoscope should have been used. The plaintiff, pregnant with her second child, told the court that she was very afraid and that the incident caused a lengthy hospitalization for depression.

According to the defense, the postpartum uterus was soft or "boggy," so that perforations could result even without any negligence.

Esophageal surgery. Three days before a cancer patient died in his late 60s, a thoracic surgeon excised a portion of the patient's esophagus. An action was brought, based on allegations that intestinal tissue should have been used to extend the esophagus, preventing excessive tension in the sutures and leakage from the surgical site and thus sparing the patient severe pain and suffering.

The defense contended that there was no negligence and that a normal risk of the procedure occurred. The jury disagreed and awarded $45,000 for conscious pain and suffering. In addition, the jury found that the patient would have had a 10 percent chance of surviving for five years if the surgery had been performed properly. Accordingly, the jury's determination of $62,000 in damages for wrongful death was reduced by 90 percent and added to the pain-and-suffering award.

THE POLITICS OF HEALTH

Candidate Clinton. Readers of the *New Jersey Law Journal* have been advised that Arkansas Governor Bill Clinton is considered by knowledgeable sources to be "a staunch foe of most tort reform." The characterization appeared in an article published on March 30, 1992, and authored by Terence Moran, the assistant managing editor of the *Legal Times* of Washington, DC. Mr. Moran also quoted an Arkansas deputy attorney general as saying that, as governor, the Democratic presidential candidate "was a real consumer advocate in terms of his antitrust policy." Mr. Moran sums up: "Like few presidential candidates in recent history, Bill Clinton is an excellent lawyer, and he carries with him into politics all the strengths and weaknesses of that skill."

Americans with Disabilities Act. Under phased-in enforcement provisions of the Americans with Disabilities Act of 1990 (ADA), physicians' offices and other public accommodations must use all "readily achievable" means to remove structural and architectural barriers to access by disabled persons, and must make newly constructed or renovated facilities "readily accessible" to the disabled unless doing so is "structurally impracticable."

What is unknown is what "readily achievable" means to the United States Department of Justice, which is charged with enforcing the Act. Private citizens may sue for injunctive relief, but the Department of Justice must approve any action for damages. In circular fashion, the Act defines "readily achievable" as "easily accomplishable and able to be carried out without much difficulty or expense." Examples might include grab bars, short ramps, Braille markings on elevator buttons, wider door spaces, lowered telephones, and smooth carpeting. The definition mostly turns on cost factors and related resource constraints.

The definition may evolve through litigation, regulation, and time. In the meantime, guidelines may be obtained by calling the Department of Justice's ADA hotline at 1/202/514-0301, extension 4. See ADA Accessibility Guidelines, 56 *Federal Register* 35455 (July 26, 1991). For answers to questions about physical modifications, the Architectural and Transportation Barriers Compliance Board, a quasi-public agency, may be contacted at 1/800/USA-ABLE.

Especially problematic to physicians and other service providers may be the requirement that physical "communication barriers" in signage and alarm systems also must be removed. To illustrate, it is unclear whether a physician or other health care provider must pay for interpretation services for deaf patients.

Title I of the Act, requiring employers to make "reasonable accommodations" for employees' disabilities, takes effect July 26, 1992, for businesses with 25 or more employees, and on July 26, 1994, against other employers with 15 or more employees. The required accommodations include physical modifications of buildings, special equipment, changes in job positions, and individualized work schedules, provided that such accommodations can be made without "undue hardship." For an employer to show hardship will be a difficult burden. Discrimination in employment practices also is prohibited.

MALPRACTICE POLICY DEVELOPMENTS

U.S. tort costs assessed. Approximately $117 billion in 1987, or 2.5 percent of the gross national product—plus indirect costs such as the cost of defensive medicine—is the national price tag for the tort system estimated in a recent updated study by Tillinghast, an actuarial consulting firm, reported in *Forbes* magazine. The Tillinghast estimate is almost four times higher than an estimate growing out of a Rand Corporation study, which excluded settlement payments and insurers' administrative and legal costs. Only half of tort system costs compensate

READERS' SURVEY QUESTIONNAIRE

Please take a few minutes to complete this questionnaire. Comments expanding on your responses to Questions 1-4 are especially welcome.

1. ***To indicate the relative importance of each feature section of the "Professional Liability" commentary, please write "H" for high importance, "M" for moderate importance, or "L" for low importance in the space next to each section title and description in items (a)-(k).***

   _____ a. "Malpractice Verdicts." Summary of jury decisions in New Jersey, and explanation of possible factors influencing the result.

   _____ b. "Malpractice and Other Cases." Summary and interpretations of appellate decisions in New Jersey and other jurisdictions that involve health professionals.

   _____ c. "Malpractice Policy Developments." Review of studies, proposals, actions, and public statements affecting tort reform or liability.

   _____ d. "Malpractice Tips." Suggestions for physicians on risk prevention, drawn from newsletters or other sources.

   _____ e. "Health Care Financing." Review of studies, proposals, actions, and public statements affecting Medicare, national health reform, Medicaid, or other national or state reimbursement systems.

   _____ f. "The Politics of Health." Miscellaneous events and interpretations involving electoral politics or health policy that may interest physicians.

   _____ g. "Licensure." Actions involving licensing requirements for physicians, medical discipline, and scopes of practice or restrictions on other health occupations.

   _____ h. "Biomedical Ethics." Developments, meetings, and review of issues involving the right to die with dignity and other ethical problems.

   _____ i. "AIDS Issues." Legal, political, economic, social, and biomedical developments affecting the great epidemic.

   _____ j. "Hospital Privileges." Litigation and other actions involving economic credentialing or individual denials or loss of privileges.

   _____ k. "Antitrust." A possible section focusing on legal aspects of professional advertising, restraint of trade, monopoly, and anticompetitive actions.

2. ***For those sections to which you assigned HIGH (H) importance in your response to Question #1, indicate the effectiveness of our recent coverage of issues.***

   a. Breadth of issues covered. Coverage of the issues is:

   _____ Very comprehensive _____ Adequate _____ Too narrow

   b. Depth of discussion. Are issues treated in sufficient detail?

   _____ Yes, nearly always _____ Sometimes _____ No, or rarely

3. ***Clarity. The writing in the commentary is:***

   _____ Very easy to follow _____ Adequate _____ Too hard to follow

4. ***The format and style of the commentary are:***

   _____ Very effective _____ Adequate _____ Unsatisfactory

5. *Which of the following most accurately describes your reading of the commentary?*

_____ Usually read it all _____ Skim it _____ Low impact

6. *Describe yourself.*

_____ Primary care physician
_____ Physician in a medical subspecialty (specify)
_____ Surgeon (specify field)
_____ Emergency physician
_____ Attorney
_____ Health policy analyst
_____ Health care administrator
_____ Researcher (specify field)
_____ Other (specify)

7. *How long have you been engaged in your career?*

_____ Less than 5 years
_____ 5 to 10 years
_____ 11 to 20 years
_____ More than 20 years

8. *Additional comments welcome.*

_____

_____

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injured parties.

Practice parameters. Practice parameters would allow physicians to avoid practicing defensive medicine and could lead to the deregulation of health care, according to noted health law professor Clark Havighurst. In a 1991 article reviewed by *Personal Injury Newsletter*, Mr. Havighurst uses the term, "practice guidelines," which are defined as "systematic scientifically derived statements of appropriate measures to be taken by physicians in the diagnosis and treatment of disease."

Identifying adverse drug effects. Adverse drug events among hospital patients were identified with far greater sensitivity under a demonstration clinical information system than the usual methods allow. In an 18-month trial of 36,000 inpatients at the LDS Hospital in Salt Lake City, the information system found 731 incidents, compared to nine incidents found through normal methods. The system creates alerts, which require approximately two-person hours to investigate. Supporting the study was the U.S. Agency for Health Care Policy and Research.

HEALTH CARE FINANCING

RBRVS will change care. Nobody is sure how, but Medicare's new resource-based relative value scale (RBRVS) reimbursement system will cause important changes in physician services beyond the intended push away from surgical interventions. In the spring 1992 issue of *Medical Care Review*, a California health care administrator suggests several scenarios. Daniel F. Fahey hypothesizes that physicians may shift routine geriatric cases away from community hospitals and toward tertiary teaching centers and hospitals, may expand vertically through health maintenance organizations to channel patients into their own facilities.

Economics of heart surgery. In a large field investigation that is being touted as a major prototype study, researchers with the Bypass Angioplasty Revascularization Investigation (BARI) are exploring the relative cost effectiveness of percutaneous transluminal coronary angioplasty (PTCA) and coronary artery bypass graft in the treatment of coronary artery disease. Each of the two methods now is used on approximately one quarter million Americans per year.

At roughly $30,000 per patient, the cost of bypass surgery is about twice that of PTCA. Defenders of the bypass procedure note, however, that PTCA has a restenosis rate of approximately 30 percent, so that the difference in surgical costs is only part of the picture. BARI's outcomes-cum-expense approach is a harbinger of things to come, as physicians learn the importance of cost as a factor in clinical decision making. ☐ James E. George, MD, JD, and Neil E. Weisfeld, JD, MsHyg

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Action: Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalmic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

Indications: Yocon® is indicated as a sympathicolytic and mydriatric. It may have activity as an aphrodisiac.

Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.[1,2] Also dizziness, headache, skin flushing reported when used orally.[1,3]

Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.[1,3,4] 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to ½ tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.[3]

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References:

1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical Letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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BOOK REVIEWS

ESSENTIALS OF NUCLEAR MEDICINE IMAGING, THIRD EDITION

Fred A. Mettler; Milton J. Guiberteau. Philadelphia, PA, W. B. Saunders, 1991. The authors of this text explore their subject with the same degree of thoroughness evident in the previous editions of this publication. Indeed, readers who study this small volume will walk away with a solid, basic competency in nuclear medicine; as such, this book has become a must for residents, as well as a handy guide for the attending physician.

The first five chapters center on the technical aspects of the field. Basic physics is considered briefly, with the emphasis placed on day-to-day quality assurance problems. This latter section instructs the reader in the areas of instrumentation and radiopharmaceutical performance. Most of the chapters discuss clinical applications. Each organ system is methodically examined. Not only do the writers map out the basic tenets of scanning and interpretation, but they also provide solutions to some common problems. The latest advances in nuclear medicine are detailed. Moreover, concise tables highlight the important points of each section.

The chapter on the cardiovascular system encompasses myocardial perfusion scintigraphy, with attention given to single photon emission computer tomography scanning and the newer technetium agents, as well as to the evaluation of ventricular function, including parametric analysis. Examination of the pulmonary system involves an artful approach to pulmonary embolism that guides the novice through the analysis of V/Q scanning with inclusion of the PIOPED study. The book also covers infection and tumor localization. The last portion of the text is comprised of a chapter devoted to radiation safety, and appendices that review standard procedures.

This ready reference continues to earn a space among the nuclear medicine texts in the physician's library. ☐ Neil B. Horner, MD

GRAND ROUNDS ON MEDICAL MALPRACTICE

Francis X. Campion, MD. Chicago, IL, American Medical Association, 1992. This book constitutes a thorough review of a number of important areas of medicolegal risk for the practicing physician. It is a very thorough text in which the author, Francis X. Campion, MD, has marshalled together articles published in various medical literature. Some of the material in the book is from 1980 and, thus, raises the question about whether more recent information should have been included.

The book contains a publisher's commentary by James S. Todd, MD, executive vice-president of the American Medical Association. Dr. Todd is well known for his malpractice expertise dating back to the time when he was chairman of the Board of Trustees of the Medical Society of New Jersey and a founding member and chairman of the Medical Inter-Insurance Exchange.

The book is divided into seven chapters dealing with such subjects as the physician-patient relationship, negligence, informed consent, adverse outcomes, the impaired physician, professional liability insurance, and peer review. There also is a glossary of

medicolegal and insurance terms, an index to reprinted articles, and a continuing medical education (CME) test packet that enables the reader to obtain category 1 AMA credits for completing the test questions for this book.

The primary benefit of this book is as a reference on medical malpractice. The book's only drawback is the staleness of some of the reprinted articles. This does not constitute much of a disadvantage since the bulk of the material is applicable today. ☐
James E. George, MD, JD

OCCUPATIONAL ASTHMA

Emil J. Bardana, Jr, MD; Anthony Montanaro, MD; Mark T. O'Hollaren, MD. Philadelphia, PA, Hanley & Belfus, Inc., 1992. This book was written to fill a void; there was a need for an up-to-date, comprehensive reference source on occupational asthma. The authors attempt to provide a synopsis of occupational-related chemicals that have been introduced into the work environment that may be associated with reversible obstructive airway disease. The authors clearly stress that "medical history" is the primary and critical factor in the evaluation of patients with occupational exposure. There are over 24 chapters dedicated to the various aspects of asthma. Important in the practicing physician's day-to-day management of patients is the issue of "disability." Chapters 2 and 3 focus on worker's compensation and disability evaluation associated with occupational asthma. Chapters 7 through 20 are dedicated to specific agents that can induce asthma: bakers' asthma, isocyanate, formaldehyde asthma, and asthma related to inhalation of antibiotics, latex dyes, acid anhydrides, insects, and from working with animals. Overall, the book is a good text and would assist any primary care physician involved in the care of adult patients with reversible obstructive airway disease that may have an occupational exposure whether from work or from a hobby. This book would be a welcome addition to any clinician's library. ☐
Leonard Bielory, MD

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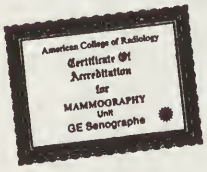
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LETTERS AND VIEWPOINTS

CHRONIC STEROID DEPENDENT ASTHMA

I enjoyed the paper on chronic steroid dependent asthma and pulmonary function (88:809-812, 1991). The article provided valuable information for consideration of both the influence of prognostic factors and the role of anti-inflammatory therapy on chronic asthma. However, one important factor that may influence the course of asthma is whether or not a person has or had a significant occupational or environmental factor causing or exacerbating the asthma. I am curious as to whether possible occupational or environmental conditions may have played any role in those who did not do well, or in those who did well because a sensitizing or irritant factor was identified and eliminated. Occupation/environment was not listed as a component of the standardized medical histories that were taken. Did the authors have this information?

In our experience at the Environmental and Occupational Health Clinical Center at Robert Wood Johnson Medical School, it is all too frequent that such remediable factors are not thoroughly explored, especially in the care of irritant exacerbated asthma, such as RADS.

This study was concerned with people who initially developed asthma in an occupational setting with exposure to well-studied agents such as plicatic acid or TDI. These patients had more persistent (exposure-independent) disease the longer they remained exposed before the nature of their illness was recognized.

Occupational histories certainly are of potential value in all asthmatics and should become a routine part of the clinical database as well as be considered in clinical research studies not directed specifically at occupation. ☐ Howard M. Kipen, MD, MPH, Associate Professor and Medical Director

SLEEP APNEA AND SNORING

The treatment of sleep apnea and snoring with dental appliances was reviewed in *NEW JERSEY MEDICINE* (88:815-817, 1991) by Dr. H. Paskow and Dr. S. Paskow. I found this article most interesting and want to congratulate the authors.

There has been a lot of skepticism among physicians regarding the efficacy of these appliances. It, therefore, is unfortunate that the authors have not included their results or the results of others. Skepticism will remain. ☐ Didier L. Peron, MD

VIRAL DIAGNOSIS

The UMDNJ/Robert Wood Johnson Medical School Viral Diagnostic Laboratory has completed its eighth year of operation. A total of 2,173 specimens were submitted for viral isolation. Of these, 514 specimens yielded viral isolates for a total positive isolation rate of 24 percent. Herpes simplex virus (HSV) was the most frequent isolate, accounting for 43 percent of the total positives. All HSVs were confirmed using Kodak Surecell (horseradish peroxidase) test kit. Cytomegalovirus (CMV) was isolated in 143 specimens via tissue culture and confirmed utilizing a CMV DNA probe. Current studies indicate that although detection time for CMV is slower using conventional methodology, rather than "shell vial" tissue culture methodology, conventional

Specimens Submitted for Viral Identification: 1991

Total submitted	2,173
Viruses identified	514
Percent positive	(24%)
Herpes simplex	219
Cytomegalovirus	143
Respiratory syncytial virus	94
Enterovirus	29
Rotavirus	15
Adenovirus	7
Parainfluenza virus	3
Influenza virus A	2
Influenza virus B	1

methodology facilitates the isolation of non-CMV (perhaps unexpected) virus from respiratory, blood, and urine specimens. Respiratory syncytial virus (RSV) was detected in 94 specimens using rapid ELISA methodology and represents the largest number of RSV isolates during any one season since this viral diagnostic laboratory was founded. A total of 29 enteroviruses was isolated. Current methodologies for confirming and typing enteroviruses still are long and tedious to perform, but nucleic acid hybridization coupled with an amplification technique soon may be available for rapid detection. Positive isolates were sent to the state laboratory and confirmed the following: Coxsackie B1(10), B3(7), B4(1), B5(6); Echovirus 7(1); Poliovirus II (2), III(1); one isolate was not confirmed. Detection with ELISA identified 15 rotaviruses on direct stool specimens. Seven adenoviruses were isolated, the same number as in 1990 and also confirmed via ELISA. A total of six influenza and parainfluenza viruses were isolated and confirmed by the laboratory. All respiratory samples were screened by hemadsorption technique and positive isolates were confirmed via immunofluorescence. The laboratory began the 1992 flu season by reporting the first influenza A (H1N1) isolate in New Jersey. We hope this summary is useful to the physicians of New Jersey and we look forward to providing services through the coming years. □ Lawrence D. Frankel, MD, Director, Laboratory for Clinical Virology, and Joseph Santoro, Supervisor, Laboratory for Clinical Virology

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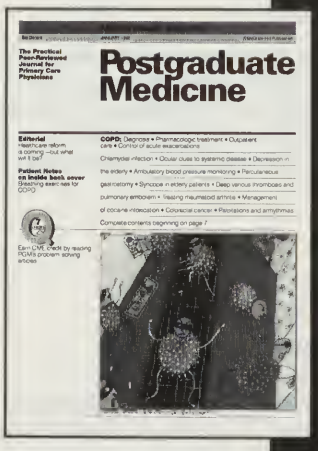
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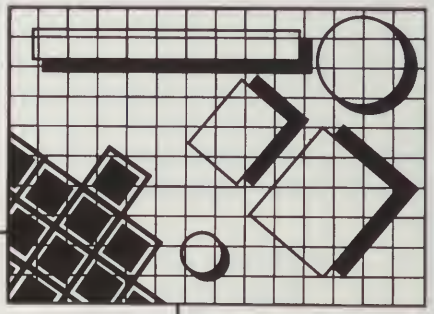
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EDITOR'S DESK

THE SILICONE BUST

The editorial of May 1992, in part, dealt with some of the problems associated with the Federal Drug Administration (FDA) and silicone breast implants. We pointed out that women were in trouble and we hoped that Dr. Kessler of the FDA would have given a clear and unequivocal decision.

Unhappily, Dr. Kessler chose to accept the recommendations of his advisory panel, which produced a mixed message. It will be acceptable for silicone implants to be used in women because of breast cancer surgery, injury, or deformity. These women will become part of clinical studies, yet to be developed. A few women desiring silicone implants for augmentation will be entered into later studies, but the numbers in this group will be a small fraction of those receiving implants before the moratorium. As Dr. Kessler stated: "No one should think we are resuming business as usual. These are not approved devices, and any woman who wants one will have to be in clinical studies." Unfortunately, not "any woman who wants one" and agrees to clinical studies can have one; very few can.

As the April 17, 1992, issue of *The New York Times* stated, "Dr. Kessler distinguished between the risk-benefit ratio for women seeking breast reconstruction and those seeking breast enlargement. In the first case, women are using implants in diseased and deformed breasts as part of their treatment, partly for psychological reasons. In the latter group, women for cosmetic reasons alone are risking healthy breasts." Dr. Sidney Wolfe, the Goebbels of consumer advocates, was quoted in the same article as saying,



Howard D. Slobodien, MD

"Women simply will not use these implants when told what the risks are, and those who do, it will be because the plastic surgeons will try to tell women there are no problems." He also revealed his delight in the developments, as noted in *The Star-Ledger* the same day, "I think it is unfortunate the FDA is allowing this experiment to continue, but basically it is all over for silicone gel implants." Way to go Sidney—no sense in trusting the integrity of any practicing physician and no point in believing in scientific tests.

It is interesting that Dr. Kessler should suggest a psychological benefit in the reconstructed woman. In February 1992, we wrote in a local weekly newspaper, "It is estimated that two million women in the United States have breast implants and that at least 75 percent of them were done for cosmetic reasons. This latter group probably is undergoing more stress than other groups. . . . Women who have had cosmetic breast implants probably are more psychologically attuned to breast imperfections than are other women. Consequently, they may be the ones most upset while awaiting final recommendations." Now that the final recommendations are here, can they be any less worried?

We have long recommended treatments of various types for medical, psychologic, and economic reasons, all considered valid indications, assuming properly informed consent. Must we decry breast implants, of whatever type, when self-image is improved or modeling and acting jobs are in the balance? Are tummy tucks a no-no? Do we ban capping of teeth and tooth implants? Are turkey necks and baggy eyes to be accepted in complete equinimity when function is not impaired? Etc., etc., etc.

All procedures, no matter how "minor," carry risks and the risk-benefit ratio noted by Dr. Kessler can be decided by the patient in most instances. It is true that there may be problems associated with silicone gel breast implants, but we are not dealing with mislabeling, contaminated products, shoddy manufacturing practices, or the concealment of known hazards of new products. We are dealing with a product with decades of clinical experience. We know that leakage occurs; it can require secondary operations. We know that encapsulation, hardness, and pain can result.

We think there exists a chance of producing connective tissue disease, although statistics have not been released; available evidence seems to represent a very small fraction of the total numbers of implants. But we also know that it does not produce cancer and many of the above-

noted problems have been publicized anecdotally. The incidence of injury still is unknown, but it seems much less than that attached to many approved products.

In our litigious society, informed consent is a hallmark of proper planning and physicians today, despite Dr. Wolfe's pronouncements, have free and open discussion with their patients, especially when procedures may be "elective" or when alternative approaches are available. As Dr. Norman Cole, head of the American Society of Plastic and Reconstructive Surgeons suggested, "The government has placed itself in the role of judging the morality of a woman's reasons for choosing breast implants."

We have no desire to deny efforts to develop alternative products or to document long-term followup; quite the contrary. We do resent the establishment of two classes—one class to have free access upon reasonable indication, the other class to be allowed access in limited numbers like winners of a lottery. We may disagree with the women who chose implants for augmentation, but it should be their choice. We wonder about the thought processes of the FDA. If the implants are safe enough to test one type of patient in significant numbers, why not the other? (Remember, the FDA is an arm of the same government with the wonderful track record on tobacco products.) Are the American people to continue having government intrude into personal freedom by protecting them from themselves? Is self-determination dead? Is the FDA over-reacting to criticism of its past activities or merely following a politically correct road in agreeing with those raising the most hell? It sure looks like mischief or flawed logic to us. Perhaps silicone implants cannot save lives the way silicone balloons (also on the FDA proscribed list) can, but you can bet we now have hundreds of thousands of unhappy and nervous American women. □

Howard D. Slobodien, MD

Let us prefer, let us not exclude.

Joseph Roux, *Meditations of a Parish Priest* (1886)

Truth's fountains may be clear—her streams are muddy, and cut through such canals of contradiction, that she must often navigate o'er fiction.

Byron, *Don Juan* (1819-1824)

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Guest Editorial: What About Prozac®?

Daniel P. Greenfield, MD, MPH, MS
Jeffrey A. Brown, MD, JD, MPH

In the May issue (pages 395-400), Philip Witt, PhD, and I discussed the diagnostic, psychotherapeutic, and pharmacologic treatment and management aspects of depression, a mainstay psychiatric condition in the practices of all physicians. One of the points we made was the advisability of using anti-depressant medications—including Prozac® (fluoxetine hydrochloride)—as adjuncts to psychotherapy and behavioral treatment approaches. These medications should be used cautiously and conservatively, paying attention to the risks (side effects) and benefits of the several classes of anti-depressants, as well as to indications for initiating, maintaining, and discontinuing these medications. This point was made about another currently controversial psychoactive drug, Halcion® (triazolam hydrochloride), a benzodiazepine hypnotic, in a companion editorial in this journal (*NJ MED* 88:889-890, 1991). We offer this guest editorial on Prozac® to put the current controversy surrounding this medication into clinical perspective.

In December 1987, Prozac® was approved by the Food and Drug Administration (FDA) for use in this country as an anti-depressant. As a selective serotonin reuptake inhibitor (SSRI), Prozac® was noted to have desirable spillover (side) effects in eating disorders, obsessive-compulsive disorders, and other psychiatric conditions, as well as undesirable side effects in both psychiatric and medical conditions. Nevertheless, Prozac® was enthusiastically received by physicians and patients, and soon became the most prescribed anti-depressant in this country.[1]

In February 1990, Teicher, Glod, and Cole published a report, in the *American Journal of Psychiatry,* with the following description, "Six depressed patients free of recent serious suicidal ideation developed intense, violent suicidal preoccupation after two to seven weeks of fluoxetine treatment. . . ."[2] Predictably, this article and its implications generated a great deal of interest and controversy among physicians, and also proved to be of interest in the legal community both as a possible factor in criminal actions (the so-called "Prozac® defense") and as a basis for professional liability litigation actions. However, later studies of large numbers of patients disputed findings that linked Prozac® with suicide in a casual way. These studies indicated, for example, that no significant difference seemed to exist between the incidents of new-onset suicidality between patients treated with fluoxetine and those placed on other anti-depressant regiments,[3] and that fluoxetine is not associated with an increased risk of suicidal acts or emergence of substantial suicidal thoughts among depressed patients.[4] Although somewhat abated now in our judgment, this controversy has continued to the present, and is another example of how prescribing practices by physicians can be influenced by a variety of nonclinical factors, including the popular press.

What about Prozac®? Is it safe? Is it efficacious? Is it dangerous? Can it induce suicidal, homicidal, or other such destructive thoughts and behaviors? In our opinion, the answer to the first two of these four questions is "yes," and the answer to the second two questions is "no." With regard to the first two questions, Prozac® has been approved as safe and efficacious by the FDA since 1987; in addition, it had been an accepted anti-depressant medication outside this country before 1987. The large research and clinical literature on Prozac® supports its usefulness as an antidepressant with other beneficial effects[6], and our own clinical experience echoes the literature. With regard to the second two questions, we fully agree with Bellak and other clinicians who believe that "as some depressed patients get better, the risk for suicide increases because it seems that they finally have the energy to commit the act (and) the increased likelihood of suicide should not necessarily be ascribed to fluoxetine itself."[6] In addition, it appears ludicrous to us that specific ideation could result from any psychoactive medication. Psychopharmacology currently is simply not sufficiently

refined or specific to accomplish such a task. The changes in mood, psychosis, anxiety, and other mental states brought about by these medications are the result of more general and sweeping changes in neurotransmitters, which do not produce changes in specific thoughts.

Putting all of these points together, we reiterate the points discussed at the beginning of this editorial: By paying careful attention to prudent and appropriate prescribing practices, by following indications and guidelines for safety, efficacy, and patient acceptance, and by prescribing Prozac® with the same caution one would prescribe any such SSRI antidepressant to depressed—and potentially suicidal—patients, this medication can be safe and efficacious, and a useful adjunct to the treatment of depression. Side effects will occur to a greater or lesser extent, as with any medication, but these can be managed by the prudent physician, taking into account the risk/benefit considerations of Prozac®, or of any antidepressant, as a physician would in prescribing any medication for any reason. ■

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Dr. Greenfield is a member of the Editorial Board of *NEW JERSEY MEDICINE;* is a managing partner with Brown and Greenfield; and is affiliated with the Department of Psychiatry at Albert Einstein College of Medicine/ Montefiore Medical Center in the Bronx, New York. Dr. Brown also is a managing partner with Brown and Greenfield; and is an attending psychiatrist at Saint Barnabas Medical Center, Livingston, and at Elizabeth General Medical Center. Address reprint requests to Dr. Greenfield, 62 Old Short Hills Road, Short Hills, NJ 07078.

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Inaugural Address: Seize the Moment

William E. Ryan, MD

Dr. William E. Ryan is the new president of the Medical Society of New Jersey. He presented this speech to the Medical Society of New Jersey (MSNJ) House of Delegates at the Society's 226th Annual Meeting in Atlantic City. Dr. Ryan is the 200th president of MSNJ.

Thank you, Doctor Sciallis, Doctor Riggs, Mr. Speaker, officers and trustees of the Medical Society of New Jersey, members of the Medical Society of New Jersey (MSNJ) House of Delegates, and friends.

It is with considerable awe and great enthusiasm that I proudly accept the role of the 200th presidency of MSNJ. It is truly a singular honor, and I thank you from the bottom of my heart for your trust and confidence.

Allow me to set the tone for my remarks by reading a quote from Act 4, Scene 3, of *Julius Caesar,* by William Shakespeare:

> Our cause is ripe.
> The enemy increaseth every day.
> We, at the height, are ready to decline.
> There is a tide in the affairs of men which,
> Taken at the flood, leads on to fortune.
> Omitted, all the voyage of their life is bound
> In shallows and in miseries.
> On such a full sea we are now afloat, and
> We must take the current when it serves
> Or lose our ventures.



William E. Ryan, MD

These lines summarize my message to you this morning. In these threatening and adversarial times, free men and women must seize the moment or forever be bureaucratically enslaved by unacceptable chains of regulation and conscription.

We believe our cause is just. That we offer the best medical care in the world to our citizenry is not an idle boast, but a reality. Our technology is par excellence. In the United States, incredible advances in cardiovascular and radiological interventional techniques have revolutionized our treatment options. Extensions of laser and laparoscopic techniques have added dimensions to our care never before conceived. These are but a very few of a long list of breakthroughs that have significantly increased our ability to relieve suffering and prolong life.

While this most current technology has been our strength, it simultaneously has been our undoing. These advances have contributed heavily to increases in medical expenditures. In this era of medical consumerism and cost consciousness, we have been assailed as in no other previous era of medicine. Critics charge vociferously that accessibility has been and is being denied. Personally, I—and I am sure this is true of all of us—know of no patient who has been denied sophisticated medical technology when the case warranted.

Yet, our foes do increase every day.

We are under daily surveillance by The Peer Review Organization of New Jersey, Inc., whose agents practice "stealth" medicine, and make unfair "Monday morning quarterback" decisions against responsible health care professionals. We are harassed by managed care systems who seem to have legions of inquiries and few working callback lines, constantly questioning our every decision. Hospitals have been increasingly

estranged; especially challenging us on issues of credentialling and authorship of constitution and bylaws.

Even the State Board of Medical Examiners (SBME), with ten sitting physicians, now is compelling us by rule and regulation, to adhere to a managerial system and practice format that is unrealistic, oppressive, and economically destructive.

Governments, both local and national, have acted unilaterally to impose constraints upon us, forcing us to provide services of dubious value to our patients at substantially increased overhead costs. Witness the new OSHA requirements for bloodborne pathogen guidelines; the new State Health Plan; the new Health Care Financing Administration (HCFA) Medicare form; and the CLIA and Medicaid DUR regulations.

Each of us feels that we have been manipulated, coerced, harassed, and dehumanized by these fortuitous assaults on our integrity.

Clearly, we are being put in an increasingly untenable position. We must rise up as a collective force and put those responsible on notice that we will accept no substitute for the best in patient care, and that irresponsible regulations have reached an end.

The MSNJ Board of Trustees, on April 15th, adopted suggestions of the Council on Legislation concerning the development of a new subcommittee to be proactive in developing initiatives and model legislation in multiple areas. The committee, headed by Dr. John Capelli, will address such issues as mandatory assignment, the Health Care Cost Reduction Act, tort reform, balance billing under no-fault, and a series of other subjects. I also plan to be extremely active in this area. Together with our staff and lobbyists, we can seize the initiative. We need to take a more positive role in shaping our destiny.

Membership over the past several years has been "flat line." Physicians see dues as too large an asking price for what they believe is of dubious value and success.

Much of what has been done for physicians here in New Jersey and nationally is not publicized to the membership, and the actions taken are not understood. How many MSNJ members know that MSNJ was instrumental in the defeat of mandatory Medicare assignment again, for the third time, in the New Jersey Assembly, and that this action saved each of us thousands of dollars more than the cost of our dues? How many know that universal assignment and mandatory Medicare acceptance were successfully argued against by MSNJ, and did not become major legislative issues?

On the national scene, the American Medical Association (AMA) was successful in getting HCFA to replace 13.2 percent of the 16.5 percent conversion factor that took place under the resource-based relative value scale (RBRVS) as of June 1991. Nine billion dollars were restored to the federal government for physician services. No other federal budget cut was restored at that time. This fact is largely unknown or unappreciated by the average physician.

As we approach the future, the waters widen and become swifter and more treacherous. New challenges of major consequence face us. Change is inevitable. As Dr. Jim Todd of the AMA has said, "The status quo is not an option."

There are many issues confronting us. I would like to spend a few moments on national health insurance, Medicare/RBRVS, and the State Health Plan, as a few standout examples of areas in which we can and should involve ourselves and concentrate our efforts.

The debate over national health insurance—although perhaps an expedient to develop a middle class economic issue—will continue and be part of the national campaign dialogue this coming year.

There currently are over 30 bills in Congress on national health policy and national health insurance. They boil down, in my estimation, to a referendum on whether the populace wishes a program that is government-run, single payer, and bureaucratized, or a health plan that is pluralistic, multipayer, and subject to market forces. These latter plans appear to offer more freedom of choice for patient and physician. All have written into them elements of cost containment and address access in different ways. Few, however, address the payment mechanism that is crucial to the political debate.

Many states have taken the initiative in developing mini-national health programs. In the Sunday, April 19, 1992, issue of *The New York Times,* it was pointed out that Minnesota is adopting Health Right, a state-subsidized program for overhauling medical care and controlling costs in that state. Other states, including California, Florida, and Ohio, also are addressing the issue.

The point is that we need to develop a position. We must visit the issue with intensity and deliberate activity to seek out what we, as a profession in New Jersey, appreciate as an acceptable plan. The day is coming when we will need to put something on the table, and it should be well conceived ahead of time.

The second item of immediate concern is Medicare and RBRVS, and in particular, the new changes that seem to be coming through on an ad hoc basis unilaterally from HCFA, especially relative to reimbursement changes in the Medicare law and its interpretation.

Ideally, RBRVS seemed logical and addressed payment inequities that everyone agreed existed under our previous methodology of reimbursement.

I support the concept of RBRVS, especially as it was expressed by Dr. Levy in the

August 8, 1990, issue of *JAMA*. He stated, "The medical profession's best articulated concern was that payments for evaluation and management services were systematically and (unfairly) lower than those for technology-based services such as surgery and imaging. Many CPR (customary, prevailing, and reasonable) critics felt that this payment bias created a strong incentive to enter high-technology specialties and to provide too few evaluation and management services."

That philosophy was adopted unanimously by the House of Delegates of the AMA during its Interim Session in 1988.

However, there have been far-reaching problems with the program as it has been applied. The principal investigator and contributor, Dr. William Hsaio of Harvard, points out that there are many misconceptions and mathematical miscalculations that mitigate against the plan's usefulness and vitiate its intent.

Clearly, the application of this program must be viewed vigilantly. I believe the jury still is out. Our program on Sunday on RBRVS with Tom Reardon, MD, I believe, gave you a good perspective.

I feel we should recognize Dr. Lois Copeland of Bergen County, for her efforts to gain some relief from Medicare oppression by litigating a question of contractual freedom.

Unfortunately, her position appears, on the basis of legal precedence, to have a low probability of success. My own feeling is that we must somehow preserve balance billing, and be allowed to receive compensation from supplementary insurance. Otherwise, the Medicare program of today will turn into a Medicaid program for those over 65 with all the distressing features of accessibility that are so well known.

In the interim, I am working closely with the medical assistants, a fine group of individuals whose leader, Judith Bender Gangemi, CMA, to develop effective administrative help in dealing with the Medicare program. This is expected to take the form of resource-type assistance. We realize that for most of you the adoption of RBRVS and its coding has been a tremendous burden that has been foisted upon you and your staffs on short notice, and that has the potential for fiscal disaster.

With respect to uncompensated care, I point out that physicians as a group still have not been recognized for inclusion in any reimbursement formula or mechanism under this trust fund. A new plan is being developed for the future, and it must include us.

Three years ago, Dr. Molly Coye, then state health commissioner, publicly stated that approximately 500 million dollars of free care was being given annually to indigent patients by physicians across this state. We did this out of largesse and concern for the unfortunate. Because of increasing overhead costs, and the issue of basic fairness, it is appropriate that physicians be reimbursed for their services under any new state program, much as the hospitals and others are reimbursed. I, therefore, am asking the Council on Medical Services, and, in particular, its new subcommittee, to develop an equitable approach to physician reimbursement under uncompensated care.

Finally, a word about the State Health Plan, about which you have heard much of late. The Plan is overreaching and draconian and, as you know, leaves little to consumer choice or marketplace competition. Conceived in relative secrecy, this Plan has been hotly debated in recent weeks as aspects of the program have gradually been made public. You are well aware of the principal features that have to do with closure of 27 pediatric units; of the phasing out of some 2,000 hospital beds; of the closure of six hospitals; and of the markedly reduced flow of capital expenditures for hospitals, and virtually none for physicians. It would severely impact physician ownership of referral facilities. It virtually banned new cardiac services, and prevented new nursing home construction for a period of about ten years. We found the entire program highly unacceptable.

We, therefore, have taken our case to the Legislature, which so far has been responsive. Assembly Bill A-1144, which basically makes the entire State Health Plan advisory, has passed the Assembly and is pending in the Senate.

We recently have met with the leadership of both the Senate and the Assembly to develop a consortium of health care professionals, to create a health plan that hopefully makes more sense. This time, we have been asked to participate, and we can see the fruits of our political labors.

As you know, this November, 13 seats of the House of Representatives will be voted upon in New Jersey. It will be vital for us to involve ourselves in these campaigns. JEMPAC again is expected to be extremely active, and Dr. Harry Carnes and the organization—hopefully—again will play a critical role in developing support and funds for candidates.

I greatly appreciate the individual efforts and very active participation on a regional basis of many physicians who have been excellent fundraisers and communicators of medicine's cause. In the long run, however, we are a much stronger state JEMPAC/MEDAC. It is my intention to see to it that those PACs that have been influential and have raised significant contributions for candidates, do get an opportunity to distribute political funds from JEMPAC to candidates in the name of MSNJ. Such effort connotes cohesiveness and unity and, coming from MSNJ, makes more of a statement of support.

I realize that medicine changes very rapidly; in fact, with terrify-

ing reality that staggers us all. I, therefore, feel it inappropriate to wait a full 12 months before revisiting current issues and to entertain new concerns. Other states have meetings more than once a year, and I feel that in November we should convene, perhaps in Lawrenceville, on a limited basis, as we did with the PA issue.

I know and sense, as you do, that we are at full sea with a series of concerns that shape the destinies of us all. If we fail to seize our opportunities, however, we will have no one to blame for our miseries and our shallows but ourselves.

Many of you, I am sure, feel that my theme from Shakespeare is perhaps too late, unfeasible, or unrealistic. However, five years ago, no one would have thought that the Russian Empire, the USSR, would have crumbled like a house of cards in such a short period of time. Despite the fact that the people lived under subjugation for years, their hearts yearned for what was appropriate and just and humane and free. Our concerns are theirs as well. Certainly, the USSR looked monolithic, as HCFA does, but then the voices from Gdansk, Riga, Vilnius, Kiev, and other regions of the Empire began to emerge and signify a different direction and thrust for the Russian people. In a short period of time, the Berlin Wall was down, Eastern Europe was freed, churches were conducting religious ceremonies, and the hated "hammer and sickle" would fly no more over Red Square. It took an organized effort of free men and women who had decided that enough was enough. Their inner yearnings and passion for humane and just conduct had to be realized. As one philosopher put it, "Nothing is impossible to those who struggle with a free heart." We can win with similar leadership and effort. We will prevail.

In closing, a reminder to us to always behave as professionals. No matter with whom we are dealing, we enjoy a certain respect and admiration in society. Perhaps we are thought to be unjustly rewarded economically, but for the most part, no one questions our hard work, our dedication to patient care, and our ethical values. This has been recognized from time to time, and I want to leave you with the uplifting sentiment of Robert Louis Stevenson, who many years ago wrote the following verse:

> There are men and classes of men that stand above the common herd:
> The soldier, the sailor, and the shepherd not infrequently;
> The artist rarely; rarer still the clergyman; but the physician almost as a rule.
> They are the flower of our civilization.

Take heart—and remember that in all your professional dealings, no matter how troubled or bleak the situation may be, you still are the flower.

Thank you very much for the opportunity of addressing you today. I hope to justify your trust in me.

God bless. ■

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Presidential Address: Keep on Hoein'

Joseph A. Riggs, MD

Dr. Joseph Riggs presented this speech at the 226th Annual Meeting of the Medical Society of New Jersey. Dr. Riggs reflects on his year as MSNJ president and his hopes for the Society and for medicine as Dr. William E. Ryan assumes the presidency of our prestigious organization.

The title of my farewell address is the same title I used one year ago for my inaugural address, "Keep on Hoein'." A year seems like a long, long time when there is much hoeing to do each day, especially when the job being done often is criticized and not always appreciated.

Also, it seems that everyone is trying to get involved with growing a crop. Lawyers ride by the fields, seeking one plant that may have been injured and ignoring all the plants that are healthy and flourishing, so that they can sue the farmer for more than the entire crop is worth.

Politicians, who never see the rows, make rules and regulations on how long a farmer can hoe each day, whether he can use equipment in which he has invested, how much fertilizer he can spread, and what prices he can charge.

In the meantime, the public demands the best possible produce at the cheapest possible price, while complaining that the crop looks better on the other side of the fence. Soon there will be fewer farmers, and more and more ancillary workers, who have never been trained as farmers but will be allowed to determine what and when hoeing will be done.



Joseph A. Riggs, MD

Sooner or later, the farmers will have to join together, and get involved in matters other than hoeing, so they can have the freedom to hoe and grow crops in the manner in which they know best. My fellow physicians, does that sound familiar to you?

At the beginning of my term in office, I promised myself that I would try to be patient and not lose control; that I would not try to dominate, intimidate, mandate, or manipulate—and I feel that I have followed that course.

I have tried to be a leader, a proactive, positive leader, a leader who hoed along with the workers; not just as a boss, but as a co-worker, always encouraging those doing the hoeing that the grass was not too high to hoe. And throughout the year, we always have hoed together, because together there was no problem we could not solve—there was no field too hard to hoe, if we stayed united.

Last year, I mentioned that my dad once told me to never look back—"just put your head down and keep on hoein'." Yet, the time has come for me to reflect back through the year and account for all the rows hoed this past year.

Four unexpected issues—AIDS, RBRVS, CPT codes, and the State Health Plan—occupied most of my time. In spite of that, we did complete some of the things we set out to do. I do not intend to reiterate all the accomplishments and failures, the hits and misses, or even speculate how much there is yet to do. They are very thoroughly detailed in my Annual Report that already has been submitted to this House. Rather, I will give just a few reflections and then move on to hoe another field.

This certainly has been the busiest and fastest year of my active life. We have done much hoeing together, maybe not always what or how everyone liked, but we always tried hard.

The best part of the year was meeting with the membership, listening to their ideas and concerns, observing how hard they are "hoeing" in their county societies, and at their committee assignments. What gratification it has been to see and know that there are so many physicians who care enough to spend time to preserve freedom for our patients and for our profession.

The worst part of the year was not being able to convince more physicians to become members so that they can share in our work. To paraphrase Abraham Joshua Heschel, from the book, *The Servant Leader*, "The greatest sin of man is to forget that he is a servant leader. All worlds are not made of exaltation, and everyone is charged to: Lift what is low; Unite what lies apart; To advance what is left behind. All worlds are full of expectancy and sacred goals, and it is the task of the servant leader to see that these things come to pass." However, I am encouraged that the strong personal, one-on-one efforts of the Committee on Women in Medicine, the Committee on International Medical Graduates, and the Committee on Membership eventually will result in increased membership. As servant leaders, we must seize the moment to get involved, as only physicians can! Ony then will our future be filled with promise, hope, and brightness.

Until now, I have expressed my gratitude by deeds and not words; but now is the time to express in words my thanks to all of you, the House of Delegates, for electing me and allowing me the privilege and honor of serving as your president. This is a magnificent organization, and Lola and I could not be more proud and grateful for the opportunity to represent you. Your personal kindness has overwhelmed us. And how generous you have been to take us into your hospitals, your county societies, and your hearts! It does not get any better than that!

I especially want to thank Dr. John Madara, the ultimate ambassador of good will, who first inspired me when he was MSNJ president in 1976, as he stressed the four words, "fun, fight, faith, and freedom!" I have tried to emulate Dr. Madara by being the most traveled president (having addressed 19 out of the 21 county societies, and having visited four neighboring state societies). I have set my tractor on automatic pilot, as I traveled to Lawrenceville more than 50 times this year.

Be assured that anyone who had contact with me had to hoe harder than they ever had before. Therefore, it is proper at this time to give my heartfelt thanks to the officers, the Board of Trustees, all MSNJ councils and committees, the House Speakers, the AMA Delegation, and the reference committees of this House for the time and effort expended to make this year a success.

The same expression of gratitude goes to the exceptional staff at MSNJ. One of the best rewards of this office is having the opportunity to work closely with such professional, multitalented, and industrious persons—the staff at MSNJ—under the direction of the most experienced and informative executive director of any medical society in the United States: Vincent Maressa, and our very devoted assistant to the executive director, Diana Gore. Neil Weisfeld, director of education, research, and regulatory affairs, also has been extremely helpful. Eileen Pfeiffer and Dr. Donald Holtzman are to be congratulated for working out the many problems associated with making accommodations for such a large meeting—our Annual Meeting. Too often, this fine staff is taken for granted and goes unrewarded and unrecognized for their special dedication to us, and I thank them publicly for the great work they have done.

I want to take a moment to thank the Camden County Medical Society, and especially Ardith Lane, for their support of all my endeavors over the past 30 years. It was there that I gained experience and received encouragement to go forth into state activities, and always will be most grateful and indebted to them.

It is so easy to forget about the group to whom we owe the most: our patients. We owe them competence, respect, compassion, caring, and every consideration. We can give them no less. However, this year they have had to wait for me, accept delays, tolerate interruptions, and remain understanding when I was too rushed to answer all their questions. I thank them for being patient patients, and hope to return once again to the personal touch and devoted attention I always have given them, and that they deserve.

It has been a hard year and an easy year. Hard, because of the vast amount of hoeing to do in all fields. Easy, because of all the help and support that many of you have given to me. Please permit me a few personal observations. No one has been more supportive during this year than my office staff and my family. I want to thank my personal office staff for repeatedly changing and rearranging my office schedule, almost always at the last moment, and for accepting all the interruptions caused by numerous telephone calls that wreaked havoc with office efficiency. They have been devoted and understanding, and handled each situation with grace and patience. Likewise, I want to thank my personal family, especially Lola, for all the driving, listening to the same speeches, and for being devoted during my times of preoccupation with Medical Society activities. Also, my son John has literally carried the entire practice during the year, without complaint, during the many times that I was away tending to Medical Society matters. I am most grateful to all of them.

Finally, I want to thank the good Lord by paraphrasing Deuteronomy:

"I have brought to you the first fruits of the soil, which you, O

Lord, have given to me. As we make merry over all these good things, we thank you, O Lord, for all our blessings."

Indeed, I do thank the good Lord for allowing me to leave:

A trail of enthusiasm;

A trail of optimism;

A trail of kindness and joy;

A trail of generosity and thoughtfulness;

A trail of love and loyalty;

A trail of faith and hope;

A trail of gratitude!

The good Lord has given me courage and strength and endurance and energy as I hoed along each day, and without His love and guidance I could not have survived.

In closing, I am not sure in what fields the Medical Society will be hoeing at the turn of the century, but right now I am bullish on health care in New Jersey in the 1990s. It will be the most exciting decade for health care reform in New Jersey's history. One thing for sure, I see strong leadership from Dr. Bill Ryan, our next president. You see, he already has begun to be president, as I have called upon him on many occasions this year to hoe some fields when I could not be in two places at one time. I can assure you that he knows very well that we are professionals and as physicians, patient care is our prime concern. Caring for patients, being kind to them, feeling with them, and hoeing for them is always first and foremost in our minds, and I am confident that Dr. Ryan will do the job.

Lastly, I have seen the presidency from the bottom up and from the top down. I know very well how it looks both ways, and I like what I see. Therefore, Dr. Ryan and good members of the House of Delegates, it is my full intention to "keep on hoein' " with you so that we may keep our society up to the highest ideals and standards it always has enjoyed. God bless. ■

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MSNJ Auxiliary President: Marion Hughes Geib

On May 5, 1992, Marion H. Geib was inaugurated as the 66th president of the Medical Society of New Jersey Auxiliary. Mrs. Geib, a member of the Gloucester County Medical Society Auxiliary, has been involved with Auxiliary affairs for over 20 years.

Marion Hughes Geib is the 66th president of the Medical Society of New Jersey Auxiliary (MSNJA). She is the wife of Thomas L. Geib, MD, a general surgeon and president of the medical/dental staff of Underwood-Memorial Hospital (UMH), Woodbury. Dr. and Mrs. Geib have two daughters: Elizabeth, a fourth-year student at Temple University School of Medicine; and Tara, a graduate student in the nursing program at the University of Pennsylvania.

Marion was raised in Haddon Heights; the daughter of the late James L. Hughes, Jr, DDS, 47th president of the Southern Dental Society of New Jersey, and the late Marion Costello Hughes, former president of Gallagher Brothers Fuel Oil Company.

Marion graduated from Saint Mary of the Angels Academy, Haddonfield, where she was an honor student and president of the student government. After receiving her bachelor of science degree from the University of Pennsylvania, she taught for five years at Tatem School, Haddonfield. While pursuing graduate work at the University of Pennsylvania, Marion worked in the



Marion H. Geib

plywood department of a family-owned wholesale millwork company.

Following her marriage to Dr. Geib in 1966, Marion joined the Gloucester County Medical Society Auxiliary (GCMSA). Working for organized medicine and health-related charities was natural for Marion, who comes from a great medical family. At least a dozen members of her family are in the health field, including her brother, James L. Hughes III, MD, a cardiologist; her brother-in-law, Joseph P. Burns, Jr, MD, an obstetrician-gynecologist; a sister-in-law, Jane S. Hughes, MD, a radiologist; and a late uncle, Frank J. Hughes, MD, an obstetrician-gynecologist and past chairman of the Medical Society of New Jersey (MSNJ) Board of Trustees. Her sister, Elizabeth H. Burns, CPA, is a member of the MSNJA Executive Board and serves on the Finance and Budget Committee of MSNJ.

As a member of GCMSA, Marion served as chairman of many committees in the organization. She held the offices of treasurer, 1983-1985; financial secretary, 1985-1986; president-elect, 1986-1987; and president, 1987-1989. From 1987-1991, Marion served as editor of the county newsletter that she created during her first year as president; the format later became a model for the state publication, *The Shingle*.

In 1985, Marion began working at the state Auxiliary level; she served on the Long-Range Planning Committee, 1985-1986, 1988-1992; Membership Committee, 1988-1991; Publication Committee, vice-chairman, 1988-1989; co-chairman, 1989-1992; co-editor, *The Shingle*, 1989-1992; Finance and Budget Committee, chairman, 1988-1990; and Executive Committee, 1988-1992. Marion's elected positions include: delegate to the American Medical Association Auxiliary Annual Sessions, 1989, 1991, 1992;

director, 1988-1990; treasurer, 1990-1991; president-elect, 1991-1992; and president, 1992-1993. For MSNJ, Marion served on the Committee on Finance and Budget, 1988-1990; the Committee on Long-Range Planning, 1991-1992; and the Committee on Publication, 1989-1992. In addition, she writes a monthly column for *NEW JERSEY MEDICINE*.

Besides her Auxiliary endeavors, for many years, Marion has been a volunteer and member of the Sponsor Committee of the UMH Horse Show and Fair. In 1991, she also served on the UMH Foundation Ball Committee. She is a member of the Republican Party and was a volunteer in the presidential campaign of Ronald Reagan. Her efforts were useful in the congressional campaign of her "Aunt Katch" Granahan (D, PA), treasurer of the United States, 1961-1964. Marion attended the inauguration and inaugural balls of Presidents Kennedy and Reagan. This year she is participating in "Campaign '92."

On the homefront, Marion was involved in parent-teacher associations and various school associations for over 15 years. Her favorite memories include watching her daughters become proficient horseback riders, musicians, and high school varsity tennis players. She also enjoys water sports, walking on the beach, playing the piano, and collecting 18th century antiques. ■

Applications of MRI for Diagnosis of Cardiovascular Diseases

Robert M. MacMillan, MD

Magnetic resonance imaging (MRI) acquires high spatial resolution images of the heart from any part of the cardiac cycle and in any planar configuration without use of contrast. Sequential images through the cardiac cycle can be viewed as a cine.

As a result of work by Bloch and Purcell, for which they received a Nobel Prize in 1952, nuclear magnetic resonance (NMR) was used until the early 1970s exclusively in scientific laboratories for chemical analysis. Lauterbur and Damadian demonstrated the feasibility of generating images using magnetic resonance during the 1970s.[1,2] Magnetic resonance imaging (MRI) appeared in clinical use during the mid-1980s and now has been applied to almost every major organ system.

MRI has a potential broad application to the heart as a noninvasive imaging modality.[3] Initial experience has utilized the spin-echo pulse sequence technique with electrocardiogram (ECG) gating that produces contrast between high signal intensity from myocardium and no signal from flowing blood (Figure 1).[4-6] High-spatial resolution images are produced from selected parts of the cardiac cycle. Recent developments have led to the introduction of cine MRI by which images at a single level through the heart can be acquired consecutively with sufficient resolution to permit the heart to be viewed in motion as a cine loop (Figure 2).[7-8]

MR SCANNER

There are more than ten manufacturers of MR scanners. There are varying field strengths based upon the type of magnet employed, e.g. permanent iron core or superconductor and upon the desired functions of the unit. For simplicity, the MR scanner used at the author's institution will be described.

MR images are generated using a 1.5 Tesla superconducting magnet (GE Signa System, Milwaukee, WI). The scanner is ECG-triggered and gated requiring 256 cardiac cycles per image acquisition. The image sample acquisition time is 25 or 33 ms. Multislice and multilevel images can be obtained. Slice thickness may be 3, 5, or 10 mm. Spatial resolution using a 40 cm field of view is 1.56 x 3.12 mm. For spin-echo pulse sequence, T_E and T_R are variable while the cine mode has relatively fixed T_E (5 or 13)

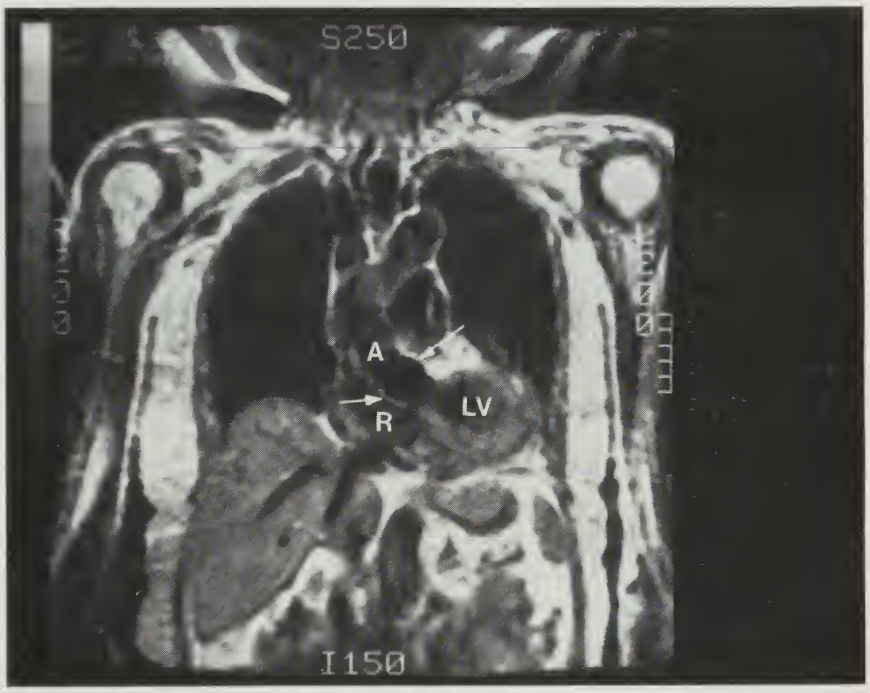


Figure 1. T_1 spin-echo pulse sequence through the heart in coronal projection: LV = left ventricle; R = right atrium; A = ascending aorta; and sinuses of Valsalva (arrows).



Figure 2. Cine MRI in the short-axis projection. Nineteen images are shown acquired through a single cardiac cycle. The first image (top, left) is end-diastole. Image 7 is end-systole. Note the progressive decrease in left ventricular cavity volume during systole, then increasing volume in diastole.

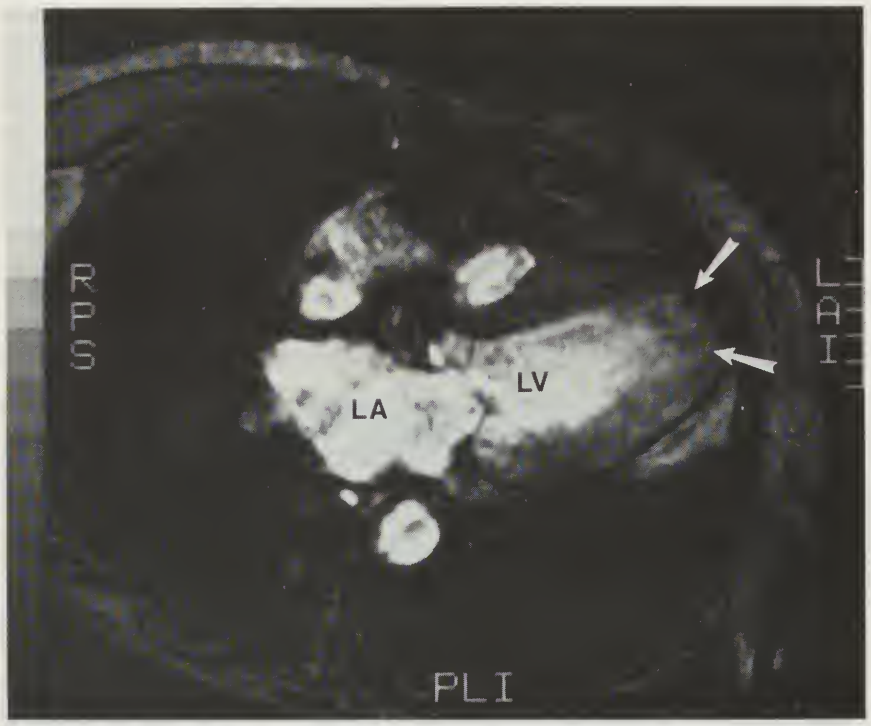


Figure 3. Long-axis cine MRI through a left ventricular (LV) central slice in systole. Note the thin, noncontractile apical segment (arrows) in this patient who had apical dyskinesis by catheterization ventriculography. LA = left atrium.

and T_R. Time of study per patient varies from 15 to 60 minutes and is dependent upon the heart rate and the number of slices desired.

PATIENT SAFETY AND SCREENING

Although some of the potential biological effects from the magnetic field and the radiofrequency electromagnetic radiation, in theory, could produce adverse reactions, in practice none has been observed.[9] A major safety hazard is the potential for injury when ferromagnetic objects enter the MR image field and are drawn toward the center of the magnet, thus accelerating as projectiles. Current absolute contraindications exist for certain implanted devices, e.g. cardiac pacemakers, automatic internal defibrillators, surgical clips for intracranial aneurysms, biostimulators, implanted infusion pumps, cochlea implants, and metallic intraorbital foreign bodies. Cardiac prosthetic valves can be safely imaged at high-field strengths with the exception of the Starr-Edwards mitral pre-6000 series used before 1965 or if dehiscence is suspected.[10]

Because the scanner gantry encloses the patient and restricts movement, subjects with claustrophobic tendencies will not tolerate this scanning procedure. Currently, patients with cardiac arrhythmias producing significant variance in the cardiac cycle length cannot be scanned in the cine mode, e.g. atrial fibrillation, frequent atrial, or ventricular ectopy.

SCANNING TECHNIQUE

Subjects are not required to fast, as no contrast agents are injected. After routine screening for metallic implants and removal of metallic clothing items, four ECG electrode patches are placed in a rectangular pattern over the left scapula. ECG leads are attached and switched around until a large amplitude R or S wave is obtained on the ECG monitor with as little interference as possible from the induction wave caused by the MRI magnetic field.[11] Occasionally, a single ECG lead is placed anteriorly just below the left clavicle to obtain a satisfactory ECG signal.

The subject is moved into the scanner gantry. A localization scan is performed to determine the location of the heart within the scanner. MRI permits scanning through the heart in any plane desired, so the plane of imaging and slice thickness are selected. Spin-echo pulse sequence or cine mode scans then are acquired.

PLANAR CONFIGURATIONS

The three orthogonal planes (axial, coronal, and sagittal) are used for scanning.[12] These planes are acceptable for the great vessels, but oblique planar slices are preferred along the long and short axes of the heart.[13] We use a modified long-axis plane that is achieved by rotating the axial plane on the y axis 15° to 20° clockwise as viewed from a coronal localizer. The short-axis plane is achieved by determining the spatial coordinates from a sagittal slice at the most anterior and inferior point of the heart and from the left atrium using an axial slice. An axis connecting these points is computer-plotted and scanning of contiguous slices is performed perpendicular to this axis. Additional planar orientations are employed to view specific cardiac structures.



Figure 4. Cine MR image with axial projection through mid-left and mid-right atria (LA, RA). Note the atrial septal defect (arrows) interrupting the continuity of the atrial septum in its middle portion. RV = right ventricle.

CLINICAL APPLICATIONS

Anatomy. The 25 msec image acquisition time of MRI freezes cardiac motion. The spin-echo pulse sequence produces images with excellent anatomic detail. Thus, MRI is useful for evaluation of cardiac anatomy. Atria, ventricles, and great vessels are seen in tomographic slices. Linear, area, and volumetric measurements of cardiac chambers and structures can be obtained. Left ventricular wall thinning from prior myocardial infarction (Figure 3), ventricular hypertrophy, and ventricular dilatation can be diagnosed.[6] Anatomic resolution is sufficient to see valve leaflets, moderator bands in the right ventricle, papillary muscles, proximal coronary arteries, and pulmonary veins. Spatial resolution currently is insufficient to detect coronary artery stenoses.



Figure 5. Cine MR image in the coronal projection in a five-year-old child with uncorrected transposition of the great vessels who previously had undergone surgical repair. AO = aorta; A = atrium; PA = pulmonary artery; LV = left ventricle; RV = right ventricle.

Congenital Heart Disease. MRI has proved useful for detection and evaluation of congenital heart disease.[14] Atrial and ventricular septal defects (Figure 4), asymmetric septal hypertrophy, tetralogy of Fallot, transposition of the great vessels (Figure 5), single ventricle, and truncus arteriosus have been diagnosed using MRI.

MRI can be used to assess patients who have undergone corrective surgery for congenital heart disease. In eight patients who had undergone surgical repair for D-transposition of the great arteries, MRI was used to evaluate superior vena caval patency, mitral and tricuspid regurgitation, and residual shunting across the intra-atrial baffle.[14]

Cardiac Masses. The excellent anatomic detail produced by MRI makes it valuable for detection of

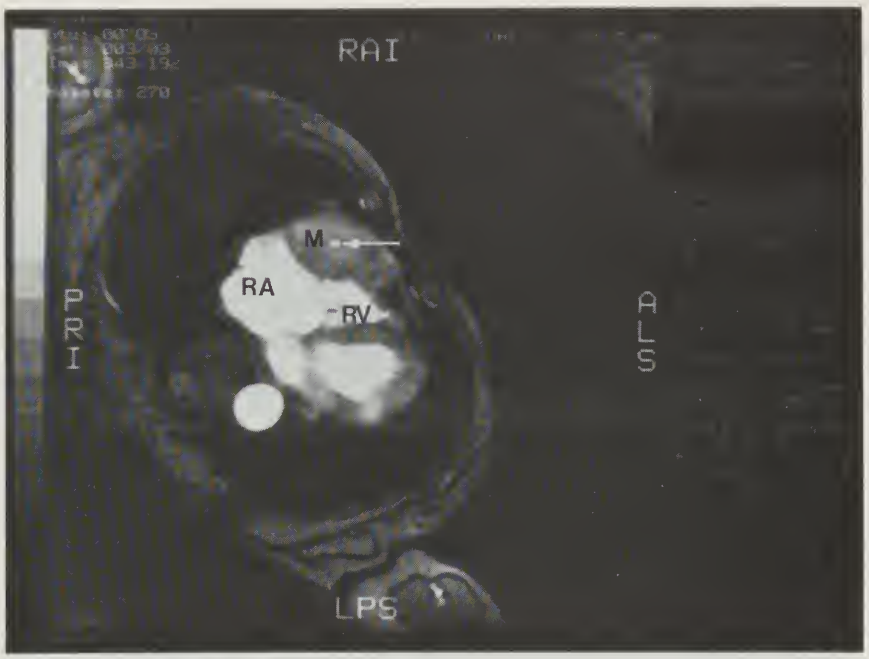


Figure 6. Long-axis cine through the heart demonstrating a large mass (M) adherent to the right ventricular (RV) epicardium. This malignant lymphoma has surrounded the right coronary artery (arrow) that remains patent. LV = left ventricle; RA = right atrium.

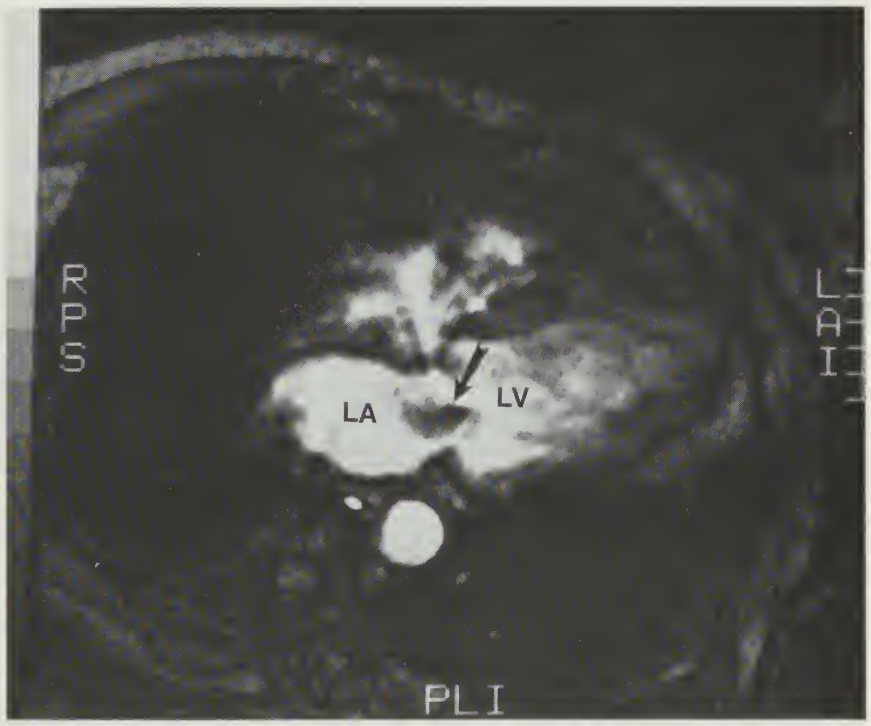


Figure 7. Long-axis cine through a left ventricular (LV) central slice in systole. Note the dark jet of mitral regurgitation (arrow) entering the left atrium (LA).

intra- and extracardiac masses. MRI has been demonstrated to depict the size, shape, and surface characteristics of atrial tumors more clearly than 2-D echocardiography.[15,16] In addition, the global field of view permits better definition of tumor prolapse, secondary valvular obstruction, and cardiac chamber size. Intraventricular thrombus, benign lipomatous hypertrophy of the left atrium, and epicardial noncardiac tumors (Figure 6) are among the types of masses that have been diagnosed by MRI. MR findings have correlated well with patients who have undergone surgical or postmortem examination.[17]

The Cardiac Valves. Though the mitral valve can be seen in many planar views, the long axis is the preferred view. Using the cine mode, the anterior and posterior leaflets can be seen opening and closing throughout the cardiac cycle. Mitral regurgitation can be detected and semiquantitated as a signal-negative jet ejected into the left atrium during systole (Figure 7). Mitral valve prolapse can be detected involving anterior and/or posterior mitral leaflets. Mitral stenosis can be detected, though not quantitated at the present time.[19]

The aortic valve is best seen using an axial or long-axis planar view. Using the cine mode, the valve leaflets are seen opening and closing. Restricted opening of the aortic leaflets is seen with valvular stenosis. We have performed 3 mm slices parallel to the plane of a severely stenotic aortic valve. A single slice demonstrated a tricuspid aortic valve and the area of the central slice could be planimetered. The catheterization-derived aortic valve area was 0.3 cm (1+ aortic regurgitation) while the MRI area was 0.5 cm. Further work is required to determine if this method is reliable. Aortic regurgitation can be detected and semiquantitated as a signal-negative jet using cine mode scans (Figure 8).[20]

The tricuspid valve is seen easily using axial or long-axis planar slices. Using the cine mode, tricuspid regurgitation can be detected and semiquantitated.

Ventricular Volumes and Ejection Fraction. Markewicz demonstrated that MRI imaging is a potentially accurate technique for measuring ventricular volumes independent of geometric assumptions using excised and in vivo canine hearts.[21] End-diastolic and end-systolic slices through the entire ventricular cavity are selected. The slice volume is de-

termined (area x slice thickness) and the sum of individual slice volumes yields the end-diastolic and end-systolic volumes. Stroke volume and ejection fraction are derived. Cine MRI derived left and right ventricular volumes using 10 mm axial slices were compared to two-dimensional echocardiography in five normal volunteers with good correlation.[22] Cine MRI derived left ventricular volumes and ejection fraction using short- and long-axis planes were compared to biplane catheterization ventriculography in 24 subjects with good correlation.[23]

Left Ventricular Regional Myocardial Function. Cine MRI can be used to assess regional wall motion abnormalities of the left ventricle and is most useful for detection of ischemic heart disease. The long-axis central slice images the septum, apex, lateral, and posterior walls. The short-axis images septum, and anterior, lateral, and inferior walls. Both oblique views are required for a complete study of wall motion. Cine MRI assessment of wall motion abnormalities was compared to echocardiography and contrast ventriculography with good agreement.[8] Hypokinetic, akinetic, and dyskinetic segments could be distinguished from normal segments.

Left Ventricular Mass. Alterations of left ventricular mass occur in a variety of congenital and acquired heart diseases. Left ventricular mass can be measured in vivo using several techniques such as contrast ventriculography,[24] echocardiography,[25] ultrafast computed tomography (CT),[26] single photon emission CT,[27] and the dynamic spatial reconstructor.[28] Many of these techniques involve use of ionizing radiation or require significant assumptions regarding left ventricular geometry.[29] MRI has been shown to measure accurately left ventricular mass in the canine model using the gated spin-echo pulse sequence.[29,30] Cine MRI using the short axis was used to determine left ventricular mass in normal volunteers and cardiomyopathy patients.[31]



Figure 8. Long-axis cine image through a central left ventricular (LV) slice in diastole demonstrating a dilated aortic root (A) and aortic regurgitation seen as a dark cloud (arrows) in the white LV blood pool.

Aortocoronary Graft Detection. Herfkens first reported imaging a coronary artery bypass graft in 1983.[32] The spin-echo pulse sequence is used. Vascular structures with normal blood flow will not generate a signal because the blood that was excited has moved out of the imaging plane. Five or 10 mm contiguous slices are acquired in the axial plane from the aortic arch to the midventricles. For a graft to be considered patent, it should have a signal-free lumen of greater diameter than native vessels seen on two contiguous slices, be seen above the origins of the native coronary arteries, and be in a location consistent with a bypass graft known to have been placed in a patient. White studied 25 patients with a total of 72 grafts using MRI and cardiac catheterization.[33] The overall predictive accuracy for determination of coronary artery bypass graft (CABG) status was 78 percent. Rubenstein studied 20 patients with 47 grafts using MRI versus catheterization.[34] The sensitivity and specificity were 92 percent and 85 percent, respectively.

Factors that limit the accuracy of MRI for detection of CABG patency include: other vascular or nonvascular structures that can produce signal void, distortion artifact from CABG rings; blurring artifact from inadequate ECG gating or from respiratory or body motion; and intraluminal signal where flow void should be present. Further limiting factors in graft evaluation include difficulty in detecting sequential grafts and inability to accurately assess graft blood flow or to detect critical stenoses.

Aortic Aneurysm. MRI provides high-quality tomographic images of the thoracic aorta. Dinsmore studied 15 patients with thoracic aortic aneurysms and compared diagnostic accuracy to thoracic aortography, CT, and ultrasound.[35] There was complete agreement between MRI and the other studies regarding aneurysm morphology and dimensions. MRI has been shown useful for diagnosis of aortic dissection (Figure 9),[36] post-traumatic false aneurysm,[37] coarctation (Figure



Figure 9. Spin-echo image through the ascending aorta in the axial projection in a patient with dissection of the ascending aorta. Note the dissection flap (arrow), false lumen (F), and true lumen (T).

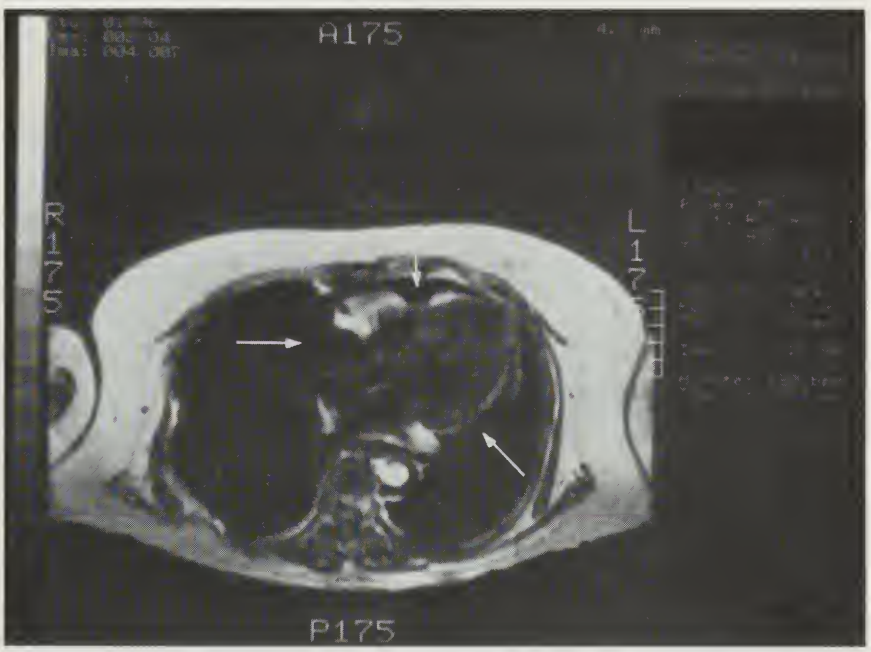


Figure 10. Spin-echo axial slice through the heart demonstrating anterior and lateral pericardial effusion (arrows).

10), Marfan's syndrome, and aortic root abscess.[38] MRI can be used to evaluate the results of surgery on the aorta.[40]

Pericardium. The pericardium and the pericardial fluid space are seen with excellent clarity over the ventricles and right atrium. Hartnell studied normal volunteers and patients with known pericardial thickening.[39] The normal pericardial space thickness was less than 3 mm. The extent of pericardial disease was well delineated including localized areas of thickening. Soulen demonstrated the use of MRI for diagnosis of pericardial constriction.[40] MRI has been used to diagnose herniation of the left ventricle through a pericardial window.[41] Hartnell concluded that MRI is at least equal to CT for pericardial examination and may be superior in demonstrating pericardium along the inferior border of the heart.[39]

New Applications. Though MR spectroscopy has been in use for chemical analysis for more than 20 years, tissue spectroscopy in vivo has only been developed recently. In contrast to MR imaging, which basically measures the distribution of water in tissue, MR spectroscopy attempts to measure the distribution of selected metabolites in tissues.[42] One such cardiac application would be spectral analysis of various forms of phosphorus in cardiac muscle. Bottomley demonstrated that exercise provokes marked changes in myocardial phosphocreatine in patients with severe coronary artery disease, while normal subjects are unaffected.[43] This technique might be a highly specific measure of myocardial ischemia.[44] Major limitations to clinical spectroscopy are related to the need for field strengths of at least 1.5 Tesla and to improving techniques for amplifying these weaker signals without increasing acquisition times beyond practical utilization. ■

Dr. MacMillan is professor of medicine and associate professor of radiology, The Likoff Cardiovascular Institute and Department of Radiology, Hahnemann University Hospital, Philadelphia. He is a member of the Committee on Publication of the Medical Society of New Jersey. The article was submitted in November 1991 and accepted in January 1992. Requests for reprints may be addressed to Dr. MacMillan, Hahnemann University Hospital, Philadelphia, PA 19102.

References available upon request.

OSHA Knocking on Doctors' Doors

Steven I. Kern, JD

New regulations by the Federal Occupational Safety and Health Administration require every medical office to train staff, offer hepatitis vaccinations, and impose universal precautions. An "occupational exposure control plan" is required of every office.

In an effort to address concerns about the transmission of acquired immunodeficiency syndrome (AIDS), hepatitis, and other bloodborne diseases, the Occupational Safety and Health Administration (OSHA) has published new regulations requiring medical and dental offices and other health care facilities to meet strict new standards for handling blood and treating patients. The new regulations supplement subpart Z of 29 CFR Part 1910 to add a new section, 1910.1030.

The new regulations require every employer having an employee with occupational exposure to establish a written exposure control plan designed to eliminate or minimize employee exposure to blood or other potentially infectious materials. Occupational exposure is defined as "reasonably anticipated skin, eye, mucous membrane, or parenteral contact with blood or other potentially infectious materials that may result from the performance of the employee's duties." Other potentially infectious materials include semen, vaginal secretions, cerebrospinal fluid, synovial fluid, pleural fluid, pericardial fluid, peritoneal fluid, amniotic fluid, saliva in dental procedures, any body fluid that is visibly contaminated with blood, and all body fluids in situations where it is difficult or impossible to differentiate between body fluids. Also included in this category are unfixed tissue or organs from a human- and human immunodeficiency virus (HIV)-contaminated cell or tissue cultures.

The exposure control plan must include a list of all job classifications in which employees have occupational exposure along with a list of tasks and procedures in which occupational exposure may occur. The plan must mandate that universal precautions be observed to prevent contact with blood or other potentially infectious materials. Universal precaution is defined as an approach to infection control under which all human blood and certain human body fluids are treated as if known to be infectious for HIV, hepatitis B virus (HBV), and other bloodborne pathogens.

The regulations mandate that engineering controls and work practice controls be put in place and maintained. These include requirements that the employer ensure that employees wash hands in washing facilities that are readily accessible to employees, and use gloves and other personal protective equipment. The employer also must prohibit employees from bending, recapping, or removing contaminated needles and other contaminated "sharps" (including scalpels, broken glass, broken capillary tubes, and exposed ends of dental wires); eating, drinking, smoking, applying cosmetics or lip balm, or handling contact lenses in work areas where there is a reasonable likelihood of occupational exposure; and storing food and drink where blood or other potentially infectious materials are present.

Special containers must be provided for disposal of contaminated sharps. Other special containers must be available for potentially infectious materials to prevent leakage during collection, handling, processing, storage, transport, or shipping. Procedures involving blood or other potentially infectious materials must be performed in a manner to minimize splashing, spraying, spattering, and generation of droplets of these substances.

Employers also have an affirmative obligation to provide and ensure that all affected employees utilize appropriate personal protective equipment including gloves, gowns, laboratory coats, face shields, masks, eye protection, mouthpieces, resuscitation bags, pocket masks, or other ventilation devices. This equipment must be designed so

that it does not permit blood or other potentially infectious materials to pass through to or to reach the employee's work clothes, street clothes, undergarments, skin, eyes, mouth, or other mucous membranes. The equipment must be provided, cleaned, repaired, and replaced, as necessary, at no cost to the employee. This equipment must be removed and properly stored prior to leaving the work area.

The employer also is obligated to ensure that the worksite is maintained in a clean and sanitary condition. This includes implementation of an appropriate written schedule for cleaning and decontamination.

In addition to proper disposal of contaminated waste, the regulation provides for placement and transportation of contaminated laundry in specially labeled or color-coded bags or containers and that any employee having contact with contaminated laundry wear protective gloves and other appropriate personal protective equipment.

Each employer also must make available to employees who have occupational exposure, the hepatitis B vaccine and vaccination series at no cost to the employee. Postexposure evaluation and followup also must be provided to all employees who have had an exposure incident, also at no cost to the employee. The hepatitis B vaccine must be offered within ten working days after initial assignment and after the employee has received the training required under the regulations. Any employee declining the vaccination must sign a statement required by OSHA.

In the event of a specific eye, mouth, other mucous membrane, nonintact skin, or parenteral contact with blood or other potentially infectious materials by an employee, the employer must provide a confidential medical evaluation and followup that includes documentation of the route of exposure and the circumstances under which the exposure incident occurred; identification and documentation of the source individual (where feasible); testing of the source individual's blood (where feasible); and baseline blood testing of the employee, if the employee consents. In addition, the employer must provide counseling and evaluation of the reported illnesses as detailed within the regulations.

All employees with occupational exposure must participate in a training program that must be provided by the employer at no cost to the employee and during employee working hours. The training must occur at the time of initial assignment to tasks where occupational exposure may take place, within 90 days after the effective date of the standard, and annually thereafter. Additional training must be provided whenever changes such as modification of tasks or procedures or institution of new tasks or procedures affect the employee's occupational exposure.

Strict criteria apply to the training including a provision that the program materials be appropriate in content and vocabulary to educational level, literacy, and language of employees.

A copy of the regulatory text of the standard and an explanation of its contents must be accessible and a general explanation of the epidemiology and symptoms of bloodborne diseases must be provided. In addition, the employee must be given an explanation of the modes of transmission of bloodborne pathogens, an explanation of the employer's exposure control plan, and means by which the employee can obtain a copy of the written plan; an explanation of the appropriate methods for recognizing tasks and other activities that may involve exposure to blood and other potentially infectious materials; an explanation of the use and limitations of methods that will prevent or reduce exposure; information on the types, proper use, location, removal, handling, decontamination, and disposal of personal protective equipment; an explanation of the basis for selection of personal protective equipment; information on the hepatitis B vaccine; information on the appropriate actions to take and persons to contact in an emergency involving blood or other potentially infectious materials; an explanation of the procedure to follow if an exposure incident occurs; information on the postexposure evaluation and followup; an explanation of the required signs and labels and/or color coding; and an opportunity for interactive questions and answers with the person conducting the training session. Records of training sessions must be maintained and the trainer must be knowledgeable in the subject matter.

The standards became effective on March 6, 1992, and exposure control plans should have been completed by May 5, 1992. Training requirements went into effect on June 4, 1992, and HBV and postexposure requirements become effective July 5, 1992. ■

Steven I. Kern is a principal in the law firm of Kern Augustine Conroy & Schoppmann, P.C. that represents physicians and other health care professionals. The law firm offers the Physician Advocacy Program providing legal representation before The PRO of New Jersey, Inc., the State Board of Medical Examiners, and OSHA as part of the MSNJ-endorsed membership services programs.

SBME Overhauls Health Care Delivery Structure

Steven I. Kern, JD

SBME requires office manuals and additional paperwork, and limits dispensing of drugs and medical equipment. Multispecialty facilities with physicians and other health care professionals are permitted in the same professional corporation, with private investors funding the company.

Beginning April 15, 1992, all physicians were subject to broad new regulations involving most business aspects of their professional practice. In what may well prove to be the most significant provision of the regulations, physicians, dentists, physical therapists, nurses, chiropractors, optometrists, and other health care professionals will be permitted to practice together as a single partnership or professional association, under new regulations adopted by the State Board of Medical Examiners (SBME). *N.J.A.C. 13:35-6.16* was adopted on January 8, 1992, over protests from past SBME president Michael Grossman, DO, that the regulations were, among other aspects, "unreadable." The regulations will have a dramatic effect upon delivery of health care in New Jersey.

Many believe that these new regulations will result in the most significant change in the delivery of health care since the institution of Medicare. Solo and small group practices may disappear even more quickly than the corner drugstore gave way to the retail pharmacy chain, according to many health care observers.

Hospitals, insurance companies, and private investors, along with individual health care providers, are expected to immediately employ this "multispecialty" vehicle to bypass federal and state fraud and abuse and anti-kickback statutes. When used in conjunction with a new corporate form also approved by SBME and contained within the same new regulations, these regulations will permit all health care professionals licensed by the Division of Consumer Affairs to join together as a limited partner to a general business corporation. That general business corporation, in turn, may have a contractual agreement with the professional service entity to provide the professional practice with all types of services of a "nonprofessional nature" such as "routine office management, hiring of nonprofessional staff, provision of office space, and/or equipment and servicing thereof, and billing services." Since the general business corporation would be a partner with the professional corporation it should fit squarely within one of the "safe harbors" of the Health Care Financing Administration (HCFA), thus eliminating possible charges of fraud and abuse or illegal kickbacks under the Medicare or Medicaid laws.

The regulations were adopted suddenly after languishing for nearly two years before SBME. Many attribute the passage to the continuing efforts of SBME members who also are employed by major New Jersey hospitals. In particular, former SBME member Robert Ambrose, MD, medical director of Morristown Memorial Hospital, and current member, Fred Jacobs, MD, senior vice-president for medical affairs at Saint Barnabas Medical Center, are credited with passage of the regulations. Both hospitals have actively pursued for-profit, spin-off corporations that included physician shareholders. These companies were seriously jeopardized by recent federal and state legislation prohibiting the referral of patients to facilities in which the physician has a financial interest.

By permitting physicians and other health care professionals to join together in a multispecialty practice, the kickback problem disappears. Since all services, from pediatrics to pharmacy, will be provided within the same corporate structure, there is no outside referral. Laboratory services, computed tomography scans, magnetic resonance imaging, drug prescriptions, eyeglasses, home care services, nursing care, and all other health care needs can be delivered through the single entity.

From the perspective of hospitals, insurance companies, and other private investors, the opportunities are phenomenal. For the first time, nonprofessionals will be able to directly invest in the professional delivery of health care and obtain profits as a partner in that enterprise. As a result, many expect that physicians will become targets of these eager investors seeking to acquire their practices and incorporate them into multispecialty facilities. By so doing, they will control all potential profit centers. The general practitioner will be the hub of activity, referring patients to his "partner" specialists and subspecialists within the multispecialty facility. The general practitioner, as well as the specialists, will order laboratory and diagnostic studies from this same entity in which they participate as partners or shareholders. Prescriptions also will be filled by their "partner" pharmacists, physical therapy provided by their "partner" physical therapists, home care services provided through their "partner" nurses, and chiropractic care will be available through their "partner" chiropractors.

The "beauty" of the new system is its simplicity. In one bold stroke, the regulations eviscerate all recent efforts of the federal and state government to remove the profit motive from referrals. Recent New Jersey law, for example, prohibits physicians from making referrals to any entity in which that physician has a financial interest. That same law restricts physician dispensing of drugs or medical devices. Federal law places similar restrictions on referrals by physicians when treating Medicare or Medicaid patients. Excluded from both laws, however, are referrals within the same bona fide partnership or professional corporation.

What is most remarkable is that few are aware of the potential impact of the regulations. The news media, for example, has not highlighted the significance of the new regulations; nor has the Legislature. One reason may be that these bold new provisions are hidden within two separate and distinct paragraphs of almost 30 pages of nearly incomprehensible language, much of which is a rehash of existing policy and legislation and virtually all of which is inapplicable to the new business arrangement provided for within the same series of regulations. Indeed, the language of the regulations deal with other issues.

Those issues include disclosure of a physician's financial interest in other health care services in which he held an interest prior to July 31, 1991, *N.J.A.C. 13:35-6.17(b);* requirements that financial interests be reported to SBME, *N.J.A.C. 13:35-6.17(j);* prohibitions on the charging of facility fees, *N.J.A.C. 13:35-6.17(c);* prohibitions on charging for free samples, *N.J.A.C. 13:35-6.17(d);* and restrictions on the amount a physician may charge for prescription drugs, over-the-counter preparations, vitamins, food supplements, medical goods, and devices such as hearing aids, eyeglasses, contact lenses, prosthetic devices, and orthotics. Charges for such items, when permitted for sale by a physician are limited to the cost of the item to the physician plus an "administrative cost," not to exceed 10 percent of the cost of the item. Discounts to the physician must be credited either to the actual purchaser or to a future purchaser, *N.J.A.C. 13:35-6.17(e).*

Also prohibited under the new regulations are investments by physicians in an entity where the dividends or any other forms of remuneration are paid on any basis other than return on monetary investment, *N.J.A.C. 13:35-6.17(g).*

Physicians, however, may be owners or investors in real estate or medical equipment used in a health care practice provided that rent, dividends, or any other forms of remuneration are received solely on the basis of the investment or fair market value, "as applicable to the circumstances," *N.J.A.C. 13:35-6.17(h).* Departing from past policy prohibiting leases based upon percentages of gross or net revenues, however, physicians may now "lease professional space from a commercial (nonprofessional) entity on any arrangements [sic] consistent with standard business practice in the community, provided that the arrangement does not affect the licensee's professional discretion in matters including choice of patients, professional services offered, or fees," *N.J.A.C. 13:35-6.17(h)(2).*

On the other hand, a physician may only lease space or medical equipment to or from another licensed health care professional to whom patients are referred, when the rent is a fixed fee set in advance and determined by fair market value, and is for a regular term and "not for sporadic use of the space or equipment," *N.J.A.C. 13:35-6.17(h)(3).*

N.J.A.C. 13:35-6.16 regulates professional practice structures and includes, among its provisions, requirements for specific policies and procedures with respect to professionally licensed personnel, responsibilities for "review and approval of hiring professional staff and timely demand for and verification of current licensing credentials," *N.J.A.C. 13:35-6.16(b).* That same provision requires physicians also to set policies regarding medical care, cleanliness of premises, maintenance, registration and inspection of professional equipment, standards for recordkeeping, security, professional propriety of billing and advertising, a written list of fees for standard services, and provide for "periodic audit of patient records and professional services to assure quality professional care on the premises." The physician also must post a notice in the waiting room stating, "Information on professional fees is available to

you on request."

These new opportunities, however, come at substantial cost to the individual practitioner. One key provision holds all physicians investing in health care services responsible to SBME for requiring maintenance of all professional practice standards and controls, without apparent regard for their involvement in the direction or day-to-day activities of the health care service, *N.J.A.C. 13:35-6.16(e)*. Thus, even passive investors, under the new rule, can lose their licenses to practice if the facility fails to maintain the professional practice standards and controls it sets for itself. The irony of this provision is that it penalizes facility investors for setting standards higher than the minimum required by law. For example, a facility that requires a physician to perform services that otherwise could be provided by a nurse, would be held in violation of the law, were a nurse then to provide these services. This would occur even though, absent such self-imposed standards, the nurse could have otherwise performed the service in compliance with law.

The regulations also formally recognize the right of physicians to participate in organized managed health care plans including health maintenance organizations, preferred provider organizations, competitive medical plans, and individual practice associations, but set out conditions for such participation, *N.J.A.C. 13:35-6.16(h)*.

The regulations also detail arrangements between physicians and laboratories, physical therapists, radiology services, and ophthalmology services.

These regulations, in addition to applying to physicians, also apply to podiatrists, bioanalytical laboratory directors, specialty laboratory directors, acupuncturists, midwives, certified nurse midwives, and all other categories of licensees "now or henceforth under the jurisdiction of SBME."

Any lawyer seeking to advise a physician or other health care professional must be aware of these new regulations and incorporate them into any structure created. Professional associations, as of April 15, 1992, no longer are a variation on the incorporation of a general business. ■

Steven I. Kern is a principal in the law firm of Kern Augustine Conroy & Schoppmann, P.C., which represents physicians and other health care professionals. The law firm offers the Physician Advocacy Program providing legal representation before The PRO of New Jersey, Inc., the State Board of Medical Examiners, and OSHA as part of MSNJ-endorsed membership services programs.

MSNJ Golden Merit Award Recipients

At ceremonies held on May 4, 1992, at the Trump Taj Mahal Casino/Resort, in Atlantic City, the following physicians received the Medical Society of New Jersey Golden Merit Award indicating they held the degree of doctor of medicine for 50 years.

Atlantic County

F. Sterling Brown, MD
..... Pennsylvania '42
James Francis Gleason, MD
..... Columbia '42

Bergen County

Hugh Auchincloss, MD
..... Columbia '42
Andrew Charles Brunhofer, MD
..... Hahnemann '42
Gerald Fisk Dederick, MD

... Medical College of Virginia, '42
Emil Dul, MD
..... Georgetown '42
William James Follette, MD
..... Buffalo '42
Arthur A. Goldfarb, MD
..... New York University '42
Vera J. McMullen Grimes, MD
..... London '42
Albert L. Higdon, MD
..... Louisville '42
Robert Clark Irwin, MD
..... Maryland '42
Vinicio G. Liva, MD
..... St. Louis '42
William Preston Magee, MD
..... New York Medical '42
Charles Robert Moog, MD
..... Jefferson '42
John Parrish O'Connor, MD
..... Jefferson '42
Doris E. Rappaport, MD
..... Woman's Medical '42
Marie Josephine Singer, MD
..... Woman's Medical '42
Thomas Joseph Sperber, MD
..... New York University '42
Anthony M. Susinno, MD
..... Long Island '42
Alfred Ralph Wollack, MD
..... New York University '42

Burlington County

Norman Kenneth Boudwin, MD
..... Hahnemann '42
Lindley Bertram Reagan, MD
..... Harvard '42
J. Arthur Steitz, MD
..... Jefferson '42
Edward Davis Wildman, MD
..... Pennsylvania '42

Camden County

James Francis Collier, MD
..... Temple '42
Lewis Lemon Coriell, MD, PhD
..... Kansas '42
Edgar Thomas Gibson, MD
..... Jefferson, '42
Luke William Jordan, MD
..... Temple '42
Benjamin Franklin Lovett, Jr, MD
..... Baylor '42
Matthew Anthony Olivo, MD
..... Georgetown '42
Charles Orlan Tyler, MD
..... Hahnemann '42
Roman V. Ulane, MD
..... Loyola '42

Essex County

Phillip Richard Apffel, MD
..... New York Medical '42
Donald Peter Beirne, MD
..... Hahnemann '42
Aaron Bernstein, MD
..... Edinburgh '42
Reynold Edward Burch, MD
..... Howard '42
Ralph L. De Filippis, MD
..... St. Louis '42
Irving Fain, MD
..... New York University '42
Fernando A. Ferrer, MD
..... Havana '42
Irene Giedrikis, MD
..... Lithuania '42
Richard Walter Greene, MD
..... Harvard '42
Frederick Gordon Hand, MD
..... Temple '42
Arthur George Hill, MD
..... Temple '42
Albert M. Silver, MD
..... New York Medical '42
Herbert Mansfield Simonson, MD
..... New York University '42
Leon I. Small, MD
..... New York Medical '42
Walter Joseph Sperling, MD
..... Cornell '42
Harriet N. Stein, MD
..... Glasgow '42
John E. Sullivan, MD
..... Columbia '42
S. Evert Svenson, MD
..... New York Medical '42*
Robert Underwood, MD
..... Hahnemann '42
Ferdinand Gerald Weisbrod, MD
..... Pennsylvania '42
Harry C. Wortman, MD
..... Duke '42

Hudson County

Harold Benjamin Bieber, MD
..... Edinburgh '42
John S. Bogacz, MD
..... New York Medical '42
Francis Anthony Dietmaring, MD
..... Jefferson '42

Joseph Giannasio, MD
..... Long Island '42
Patrick Joseph McGovern, MD
..... Downstate '42
Huerta C. Neals, MD
..... Howard '42
John P. Riordan, MD
..... New York Medical '42
Joseph Matthew Skrypski, MD
..... New York University '42

Mercer County

Bertram Maxwell Bernstein, MD
..... Hahnemann '42
Warren Eugene Crane, MD
..... Maryland '42
Arthur R. Errion, MD
..... Pennyslvania '42
Lewis J. Ledden, MD
..... Hahnemann '42
Walter George Scheuerman, MD
..... Michigan '42

Middlesex County

Bori Berkow, MD
..... New York University '42
Mohammed Waliul Haque, MD
..... Calcutta '42
William George Kuhn, Jr, MD
..... Georgetown, '42
Paul F. Zito, MD
..... Long Island '42

Monmouth County

Nicholas Joseph Arcomano, MD
..... Georgetown '42
George G. Bruzza, MD
..... New York Medical '42
Andrew Nicholas Conte, MD
..... Georgetown '42
Theodore W. Fox, MD
..... Albany '42
Bernard C. Kaye, MD
..... Laval '42
Miles S. Winder, Jr, MD
..... New York University '42

Morris County

Hugh Freer Luddecke, MD
..... Hahnemann '42
John Francis Majeranowski, M.D.
..... Edinburgh '42

Ocean County

Frank James Brown, MD
..... Columbia '42
Ira Jerome Holzman, MD
..... Long Island '42

Passaic County

Mortimer Herbert Kassel, MD
..... Lausanne '42
Hyman Jerome Levine, MD
..... Louisville '42
Carl Rasin, MD
..... Johns Hopkins '42
Michael John Ressetar, MD
..... Jefferson '42
Marvin P. Rosenberg, MD
..... New York Medical '42
Joseph Schulman Shapiro, MD
..... Cornell '42
Gopaldas M. Shroff, MD
..... Grant '42
Paul Steinlauf, MD
..... Glasgow '42

Salem County

David Grayson Neander, MD
..... Harvard '42

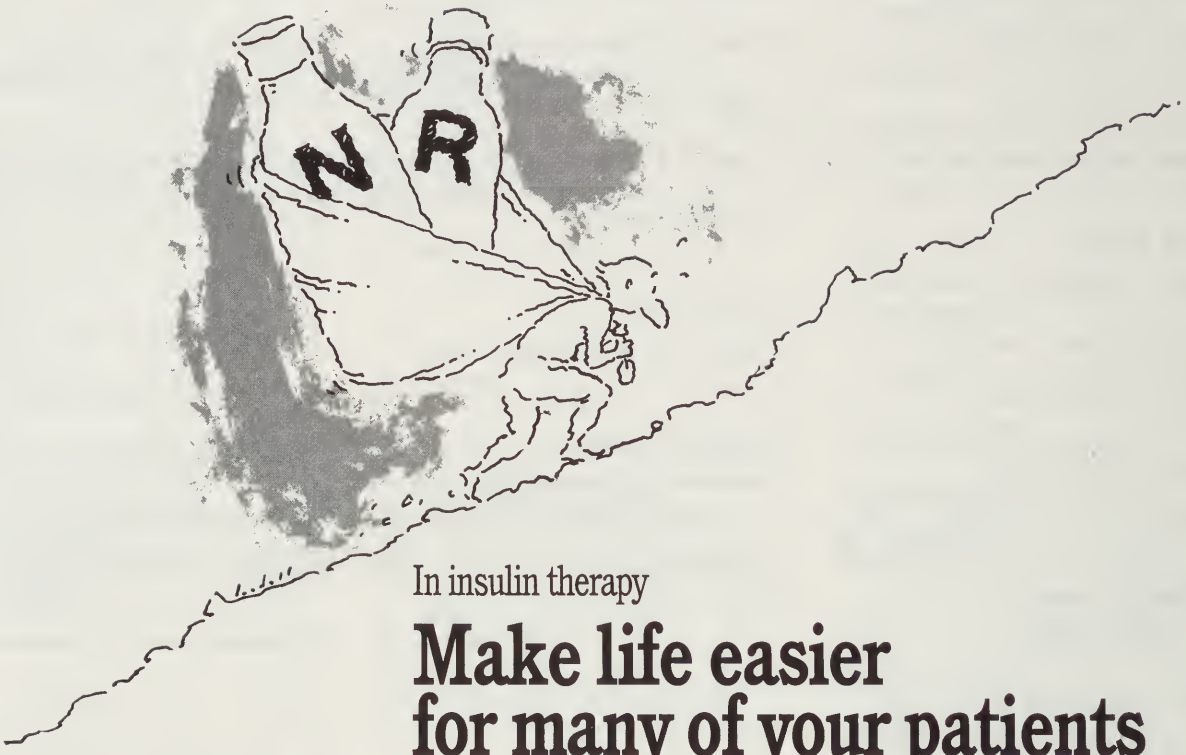
Somerset County

Theodore H. Frankel, MD
..... George Washington '42

Union County

Frank Halstead Brown, Jr, MD
..... Hahnemann '42
Kenneth Laird Day, MD
..... Northwestern '42
Bela K. Der, MD
..... Szeged '42
Robert G. Fisher, MD
..... Pennsylvania '42
Sheldon Fox, MD
..... Johns Hopkins '42
E. Wallace Friedlander, MD
..... Lausanne '42
Beatrice Prazak Lerman, MD
..... Temple '42
Sidney Robert Livingston, MD
..... Temple '42
Martha Elizabeth Maurer, MD
..... Temple '42
Earl Andrew O'Neill, MD
..... Duke '42
Stuart Orton, MD
..... Jefferson '42
Adele C. Shepard, MD
..... Northwestern '42
Manley Cadwalader Williams, MD
..... Pennsylvania '42

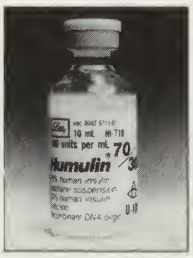
*Deceased; award posthumously.



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(recombinant DNA origin)

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46285

WARNING: Any change of insulin should be made cautiously and only under medical supervision.

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DOCTORS' NOTEBOOK

TRUSTEES' MINUTES

A regular meeting of the MSNJ Board of Trustees was held on April 15, 1992, at the executive offices in Lawrenceville. Detailed minutes are on file with the secretary of your county society. A summary of significant actions follows:

President's Report.

1. Membership recruitment. Noted an improvement in the membership of the Society is anticipated by the end of 1992.

2. State Board of Medical Examiners (SBME). Announced that Dr. Albert A. Tallone, a member of the New Jersey Association of Osteopathic Physicians and Surgeons, was appointed to SBME.

Specialty Reports. Received reports from the University of Medicine and Dentistry of New Jersey; the New Jersey Hospital Association; and the MSNJ Auxiliary.

Executive Director's Report.

1. NJSMU bylaw change. Noted that bylaw changes allow the Board of the New Jersey State Medical Underwriters (NJSMU) greater flexibility in scheduling its annual meeting.

2. Biennial licensing. Noted that MSNJ's appeal will be heard by the State Supreme Court in this case of MSNJ versus SBME.

3. SBME versus Sinha. Will prepare a summary of the Supreme Court decision for this case (an anesthesiologist whose license was suspended by SBME for his alleged failure to provide supervision of a CRNA in a given situation) for distribution to county medical societies and other individuals and for publication in *NEW JERSEY MEDICINE.*

4. MSNJ versus New Jersey State Department of Insurance (No-Fault). Concurred with the recommendation of general counsel to enter a stipulation with the state to discontinue the challenge to the fee schedule per se, and to focus on the issues involving the $100 per year license tax and the ban on balance billing.

5. Stewart/Copeland versus Sullivan. Segregated the two key issues in this case: involvement in the Copeland lawsuit and implementation of the "Freedom of Choice" fund. Voted to accept the advice of Judge Stern and not participate in the Copeland case, and directed staff to draft a resolution pursing the application of the fee limitations to doctors who treat patients who are covered by Medicare but do not seek reimbursement from Medicare; if this is adopted, the resolution will be forwarded to the AMA for consideration in June. Voted to authorize the president to contact the American Health Legal Foundation to request that the necessary materials to support fundraising be forwarded to MSNJ; when the necessary documentation is received, the president and executive director are authorized to initiate the contribution request.

6. Appointments to NJSMU Board of Directors. Will discuss scheduling of interviews of appointments to NJSME in executive session.

SBME Regulation on Corporate Business Practices. Will forward a letter to SBME opposing the new regulation on business practices and requesting that it be rescinded.

Committee on Finance and Budget. Voted to increase the budget for public relations from $136,000 to $200,000 and to increase the budget for AMA delegates from $75,000 to $90,000, for a total of $79,000 to be added to the budget for the new fiscal year, the additional amount to be funded through a draw down on MSNJ's standing reserves. Also, approved the following recommendations:

That the budget for the fiscal year beginning June 1, 1992, and ending May 31, 1993, **in the amount of $4,271,000** with $2,595,000 to be raised through member assessment, **and $79,000 to be funded through a draw down on standing reserves of MSNJ,** be adopted. Bold denotes amendment by the Board.)

That the 1993 assessment be set at $375 per regular dues-paying member.

That the 1993 assessment be set at $60 per member for affiliate members (no longer practicing in New Jersey).

That the 1993 assessment for associate members (interns/residents nonlicensed in New Jersey) and licensed residents, provided the individual is in a residency program entered upon within a reasonable time after his or her graduation from medical school, be set at $25.

That the 1993 assessment be set at $10 per student for medical students.

Committee on Membership Services. Approved the following recommendation:

That MSNJ formally endorse the Medical Services Division, Solid Waste Technologies, Inc., as a provider of medical waste management services for the membership.

Unfinished Business.

1. Reinstatement of members. Approved the following recommendation:

That MSNJ's current policy on reinstatement of members remain in effect, and that the Ad Hoc Committee on Membership continue to study

the overall issue of assessment delinquency.

2. Interprofessional code of cooperation between MSNJ and New Jersey State Bar Association. Approved the following recommendations regarding a proposed interprofessional code of cooperation between MSNJ and the New Jersey State Bar Association:

That all references to the Society be corrected to read "the Medical Society of New Jersey."

That the document be amended in all sections to indicate that subpoenas, but especially a subpoena duces tecum (a subpoena requiring a witness to produce some specified book, object, or paper in court), must be accompanied by written patient authorization unless an authorization previously was given to the physician.

New Business. Referred the following resolution from the Hudson County Medical Society to the AMA Delegation and to the Task Force on Lyme Disease of the Academy of Medicine of New Jersey:

Resolved, that MSNJ request that the Council on Scientific Affairs of the American Medical Association (AMA) study the treatment of Lyme disease, in particular the long-term use of intravenous antibiotics; and be it further

Resolved, that the Council on Scientific Affairs of the AMA report its findings expeditiously. □

UMDNJ NOTES

New drug to combat cystic fibrosis. A new drug that breaks up the sludge-like mucus in the lungs of cystic fibrosis patients is being tested at UMDNJ-New Jersey Medical School, Newark. In a short-term preliminary study of the drug, called rhDNase, researchers at the National Institutes of Health (NIH) found that the drug breaks up the mucus in the lungs into a watery substance, to give patients the ability to cough it up.

The clinical trial at UMDNJ, the first clinical trial of any kind for cystic fibrosis patients in New Jersey, will test the drug on a long-term basis to determine whether rhDNase effectively improves lung function and quality of life in cystic fibrosis patients without side effects. Dr. Nelson Turcious, a UMDNJ pediatric-pulmonary disease specialist, is principal investigator of the trial.

Muscle strength. An experimental electronic technique has proved to be accurate in measuring muscle strength in children with Duchenne muscular dystropy (DMD). In preliminary trials, a researcher adapted a common engineering tool, known as an electronic strain gauge, to measure isometric muscle force in a group of ten healthy control children and ten children with DMD. The researcher, Christine Brussock, said the new measuring technique may ultimately prove to be a noninvasive alternative to surgically removing muscle cells from DMD patients to monitor improvement or deterioration in their muscle function. Ms. Brussock, a physical therapist, is an instructor in the Master of Physical Therapy Program at UMDNJ-School of Health Related Profession.

Although no cure or effective treatment for muscular dystrophy exists, experimental treatments are being introduced, heightening the demand for better techniques to document the disease and its progression.

UMDNJ Champions. The UMDNJ Champions have awarded a total of $88,100 to three UMDNJ physicians who direct clinical programs that benefit women and children with AIDS: Dr. Patricia Kloser, assistant professor of medicine at UMDNJ-New Jersey Medical School and medical director of the Women's AIDS Clinic at UMDNJ-University Hospital, both in Newark; Dr. Lawrence Frenkel, professor of pediatrics at UMDNJ-Robert Wood Johnson Medical School and medical director of the Central New Jersey Pediatric AIDS Program in New Brunswick; and Dr. David Condolucci, assistant professor of medicine at UMDNJ-School of Osteopathic Medicine and medical director of the Treatment Assessment Program (TAP) in Stratford.

David Gibson is new dean at UMDNJ. David Gibson has been appointed dean of UMDNJ-School of Health Related Professions. He is responsible for overseeing the University's 19 allied health professional certificate and degree programs and two nursing degree programs. He had been serving as acting dean. Mr. Gibson has demonstrated that he is an outstanding administrator. He has a clear vision of the importance of allied health professionals and nurses in the health care system of the state and of the nation.

Denise Mulkern named UMDNJ vice-president for finance. Denise Mulkern has been appointed vice-president for finance and treasurer at UMDNJ. In her position, Ms. Mulkern is responsible for all of UMDNJ's financial reporting, budget, and treasury functions. She had been serving as acting vice-president and treasurer since February 1991.

Ms. Mulkern was UMDNJ controller before her acting appointment. In her eight-year tenure with the University, she also served as assistant to the controller, associate controller, and director of special projects related to technical financial issues. □

Stanley S. Bergen, Jr, MD

CONTINUING EDUCATION

July

2 **Tumor Board Conference**
9 12:15-1:15 P.M.—Mercer
16 Medical Center, Trenton
23 *(AMNJ)*
30

2 **Coping with Grief**
6:15-7:30 P.M.—Robert Wood Johnson Medical School, New Brunswick
(UMDNJ)

9 **Relaxation and Stress Management**
6-7:30 P.M.—Robert Wood Johnson Medical School, New Brunswick
(UMDNJ)

17 **Identification and Management of Asymptomatic HIV Infection**
9-10 P.M.—St. Francis Medical Center, Trenton

August

6 **Tumor Board Conference**
13 12:15-1:15 P.M.—Mercer
20 Medical Center, Trenton
27 *(AMNJ)* □

STATE BOARD OF MEDICAL EXAMINERS

A meeting of the State Board of Medical Examiners (SBME) was held on April 8, 1992. William I. Weiss, MD, was introduced as SBME medical director-elect. Dr. Weiss is a member of our Essex County component. The position of medical director was created under the Medical

Table. ***SBME actions.***

Bill	Topic	SBME Action	Comment
S-30	Arson registry	No action	
S-499	Remove limits on dispensing	Oppose	MSNJ supportive
A-550	Lower CON fees	No action	MSNJ supportive of legislation
A-565	Require parental notice of abortions	Strongly oppose	
A-588	Require SBME actions to meet clear-and-convincing standard of proof	Oppose	"Self-serving bill to keep bad doctors in practice"—SBME members
S-398	Podiatrists are physicians for purposes of regulation	Support	Already the practice
A-923	Mandatory assignment for all Medicare patients	Strongly oppose	MSNJ opposed
S-98	Mandatory HIV testing	Strongly oppose	Governor's AIDS Council opposed; MSNJ to review
A-924	HIV reporting	Strongly support	MSNJ supportive
S-331	Treat HIV as venereal disease	Support	Governor's AIDS Council opposed; MSNJ to review
A-926	Mandatory assignment for Medicare patients below certain income levels	Oppose	
S-284	Prohibit physician billing for outside laboratory fees	No action	

Conduct Reform Act of 1990, with responsibilities in the area of discipline and impairments.

Board members discussed the licensure eligibility of international physicians whose education pattern does not follow that of U.S. medical graduates. The Board took no action on this issue. The Board also discussed the question of whether a limit should be applied to the number of times a physician could take the new medical licensure examination. The issue was referred to the Credentials Committee for further consideration. The Board reviewed the question of whether an endorsement of a license from another state should require re-examination if the original licensure was granted by the other state many years earlier. A motion to require re-examination was defeated. Practice restrictions on HIV-positive physicians were discussed. The Board voted to re-affirm its current policy on a "pro tem" basis, and to appoint Dr. John Sensakovic to its task force on HIV and physicians. It is unclear whether this issue will be placed on the Board's agenda at an early date.

Much of the meeting involved a review of pending legislation. The Table depicts the actions taken. ☐

PLACEMENT FILE

The following physicians have written to the executive offices of MSNJ seeking information on opportunities for practice in New Jersey. If you are interested in any further information, please contact the physician directly.

Gastroenterology

Steven Nadler, MD, Robert Wood Johnson University Hospital, MEB 478, GI Division, New Brunswick, NJ 08901. UMDNJ 1987. Board eligible. Board certified (IM). Group, partnership, solo. Available July 1993.

Internal Medicine

Sheryl S. Hertel, MD, 6205 Brogan Pl., St. Louis, MO 63128. St. Louis 1986. Also, pediatrics. Board certified; board eligible (PED). Group. Available.

Tina M. Josephson, MD, 12043 White Cord Way, Columbia, MD 21044. Hahnemann University 1988. Group or partnership. Available 1992.

Cynthia K. Menack, MD, 3132 Perry Ave., Apt. 2A, Bronx, NY 10467. Mount Sinai 1989. Board eligible. Group practice or medical clinics. Available.

John Musico, MD, 262 Pine Valley Rd., Dover, DE 19901. St. George 1988. Board eligible. Available.

Oncology

Barry M. Yafe, MD, 107 Forest St., Providence, RI 02906. New York University 1984. Board certified (ONCOL and IM). Group or partnership. Available September 1992.

Pathology

Sarita Khanijo, MD, 1710 NW Calkins, Roseburg, OR 97470. MGM Medical College (India) 1976. Board certified. Group or partnership. Available.

Pediatrics

Sheryl S. Hertel, MD, 6205 Brogan Pl., St. Louis, MO 63128. St. Louis 1986. Also, internal medicine. Board eligible. Board certified (IM). Group. Available.

Pulmonary Medicine

Vinod Khanijo, MD, 1710 NW Calkins, Roseburg, OR 97470. Delhi University (India) 1963. Also, critical care. Board certified. Solo. Available.

Surgery

Mark A. Bartolozzi, MD, Westchester County Medical Center, P.O. Box 17, Valhalla, NY 10595. New York Medical College 1987. Board eligible. Partnership. Available. ☐

ARE YOU MOVING?

If so, please send a change of address to *NEW JERSEY MEDICINE,* Medical Society of New Jersey, Two Princess Road, Lawrenceville, NJ 08648, at least six weeks before you move.

Name _____

Old Address _____

City _____ State _____ Zip _____

New Address _____

City _____ State _____ Zip _____

NEW JERSEY MEDICINE
JULY 1992
Transactions of the
Medical Society of New Jersey

IN MEMORIAM

THEODORE A. ANDERSON

Theodore Andrew Anderson, MD, was born in Gary, South Dakota, on September 27, 1903. We received word that he died in January 1992, at the age of 88. Dr. Anderson was awarded a medical degree from Boston University School of Medicine, in 1947. Dr. Anderson completed an internship and a residency at the former Hospital of Saint Barnabas for Women and Children, Newark, and a residency at the former Essex County Overbrook Hospital, Cedar Grove. Dr. Anderson was a psychiatrist at Essex County Hospital Center, Cedar Grove. He was a member of our Essex County component and of the American Medical Association. Dr. Anderson retired to Sarasota, Florida.

DELMA W. CALDWELL

At the age of 80, Delma Wells Caldwell, MD, died on January 7, 1992. Dr. Caldwell was born in Chicago, Illinois, on January 19, 1911. He earned his doctorate in bacteriology and pathology from Northwestern University, Chicago, in 1939, and his medical degree from Rush Medical College, Chicago, Illinois, in 1941. Dr. Caldwell served an internship and residency at Presbyterian Hospital, Chicago. Dr. Caldwell specialized in industrial medicine. He practiced in Illinois and was a professor at Northwestern University before relocating to New Jersey. Dr. Caldwell was medical director at Exxon Oil Company, where he helped to establish stress testing for industrial workers. During his extensive medical career, Dr. Caldwell was president of the Industrial Medical Association of New Jersey; diplomate of the American Board of Occupational Medicine; fellow of the American College of Preventive Medicine; and affiliated with Elizabeth General Hospital, Muhlenberg Hospital, and St. Elizabeth Hospital. Dr. Caldwell researched the treatment for diabetes and alcoholism; he was awarded the Banting Junior Medal for Contributions in Research and Treatment of Diabetes and served on the Council of Alcoholism under President Eisenhower. Dr. Caldwell was on the Industrial Safety Board of the Medical Society of New Jersey (MSNJ) and was the recipient of MSNJ's Golden Merit Award. Dr. Caldwell served in the Korean conflict as a surgeon and was awarded a Bronze Star and an Army Commendation Ribbon. Later, he served as a medical advisor to the United States Army, on the health hazards of missile fuels. Dr. Caldwell resided in Westfield and retired to Sarasota, Florida.

EDWARD N. COMANDO

Born in Newark, on January 2, 1919, Edward Norman Comando, MD, of Livingston, passed away on December 31, 1991. Dr. Comando was awarded a medical degree from New York University School of Medicine in 1943; then he served in the military from 1944 to 1946. Dr. Comando received his New Jersey medical license in 1946. He completed a residency at Margaret Hague Maternity Hospital, Jersey City, and an internship at Newark City Hospital. Dr. Comando was an obstetrician/gynecologist and maintained a private practice. Dr. Comando was clinical chief of the Department of Obstetrics and Gynecology at Saint Barnabas

Medical Center, Livingston, and a consultant with the Maternal and Child Health Project for the New Jersey State Department of Health. He also was affiliated with Newark Beth Israel Medical Center. Dr. Comando was a diplomate of the American Board of Obstetrics and Gynecology; a fellow of the American College of Surgeons and of the American College of Obstetricians and Gynecologists; and a member of our Essex County component and of the American Medical Association. At the age of 69, Dr. Comando was awarded an associate of arts degree from Kean College, Union.

FRANCIS FIGLIOLINO

We regret to announce the death of Francis Figliolino, MD, on December 17, 1991, at the age of 82. He was born in New York City, on April 9, 1909. Dr. Figliolino was awarded a medical degree from the University of Bologna, Italy, in 1937. He received his New Jersey medical license in 1944. Dr. Figliolina was a gynecologist and obstetrician, and practiced in Rahway. He was attending at Rahway Hospital. He was a member of our Union County component and of the American Medical Association. Dr. Figliolino was a Rahway resident for 40 years.

WILBERT R. STAUB

A member of our Salem County component, Wilbert Robert Staub, MD, died at the age of 68. A prominent internist, Dr. Staub opened a practice in Salem County in May 1954 and retired in January 1990. Born in New York, Dr. Staub earned a medical degree from Marquette University School of Medicine, Milwaukee. He completed an internship and residency in pathology at Jewish Hospital of Brooklyn, New York, a residency in internal medicine at Goldwater Memorial Hospital, New York, and a residency at Lincoln Hospital, New York. He completed postgraduate courses in gastroenterology at the Graduate Hospital of the University of Pennsylvania. During his lengthy career, Dr. Staub was affiliated with Graduate Hospital, Philadelphia, and Memorial Hospital of Salem County, where he served as chief of medicine and chief of staff. Dr. Staub was a diplomate of the American Board of Internal Medicine and a fellow of the American College of Physicians. Dr. Staub was a captain in the United States Army Medical Corps, serving in Trieste, Italy, from 1951 to 1953.

ANGEL A. SUAREZ

A member of our Hudson County component, Angel Antonio Suarez, MD, passed away on January 21, 1992. He was 61 years old. Dr. Suarez was born in Havana, Cuba, on December 8, 1930. He was awarded a medical degree from the University of Madrid, Spain, in 1960. He received his license to practice medicine in Spain in 1960, and he received his New Jersey medical license in 1968. Dr. Suarez completed an internship at St. Carlos University Hospital, Madrid, in 1961, and at St. Mary's Hospital, Hoboken, in 1963, and a residency at Hudson County Hospital, Secaucus, in 1968. Dr. Suarez was a psychiatrist affiliated with Bayonne Hospital; Christ Hospital, Jersey City; Meadowlands Hospital Medical Center, Secaucus; Jersey City Medical Center; Palisades General Hospital, North Bergen; St. Francis Hospital, Jersey City; and St. Mary Hospital, Hoboken. Dr. Suarez was a member of the American Medical Association. He resided in North Bergen for 30 years.

JOHN S. VAN MATER

General practitioner John Stroud Van Mater, MD, died on December 23, 1991. Dr. Van Mater was born in Highland Park on June 6, 1916, and resided there for 50 years before relocating to Piscataway and Monroe. Dr. Van Mater attended Hahnemann University, Philadelphia, earning a medical degree in 1942. After receiving his New Jersey medical license the following year, Dr. Van Mater served in the United States Navy until 1946. He completed a residency at New York Lying-In Hospital, New York, and an internship at St. Peter's Medical Center, New Brunswick. Dr. Van Mater maintained a practice in New Brunswick; he was chief of staff of the Department of Obstetrics and Gynecology at St. Peter's Medical Center; on staff at Robert Wood Johnson University Hospital, New Brunswick; and an instructor at UMDNJ-Robert Wood Johnson Medical School, New Brunswick. Dr. Van Mater was a diplomate of the American Board of Obstetrics and Gynecology; a member of the American Medical Association and of our Middlesex County component; and a fellow of the American College of Surgeons and of the American College of Obstetrics and Gynecologists.

VASANT G. YADAV

Sixty-one-year-old Vasant G. Yadav, MD, died on November 9, 1991. Dr. Yadav was born on March 7, 1930, in Nagpur, India. He graduated with a medical degree from Nagpur Medical College, India, in 1956. Dr. Yadav completed internships at Nagpur Medical College, in 1957, and at Episcopal Hospital, Philadelphia, in 1963. Dr. Yadav completed residencies at Burlington County Hospital, Mount Holly, in 1959, at Jefferson Medical College in 1961, and at Children's Hospital, Halifax, North Carolina, in 1967. Dr. Yadav received his Pennsylvania and New Jersey medical licenses in 1969 and 1970, respectively. Dr. Yadav was an attending pediatrician allergist at Cooper Hospital/University Medical Center; Kennedy Memorial Hospital, Washington Township; Jefferson University Medical Center, Philadelphia; and Our Lady of Lourdes Medical Center, Camden. He was a member of our Camden County component and of the AMA.

ARTHUR D. L. ZAMPELLA

Arthur Dante Louis Zampella, MD, died on January 9, 1992. Dr. Zampella was born on May 15, 1917, in Jersey City. He was awarded a medical degree from Boston University School of Medicine, Massachusetts, in 1943. Dr. Zampella pursued postgraduate work at New York University and at the United States Naval Medical School, Bethesda, Maryland. Dr. Zampella maintained a private practice in Milford Township and Newfoundland, specializing in family practice and geriatrics. He was affiliated with Jersey City Medical Center; Christ Hospital, Jersey City; St. Clare's Riverside Medical Center, Denville; Chilton Memorial Hospital, Pompton Plains; and the United States Naval Hospital, Long Island, New York. Dr. Zampella's career included director of: Idylease Clinical Laboratory, Idylease Nursing and Convalescent Home, National Institute for Rehabilitation Engineering, Idylease Guidance Center, and West Milford Day Center. He was a surgeon for the West Milford police and fire departments; recipient of the AMA Physician Recognition Award; fellow of the American Academy of Family Practice; and member of our Morris County component, of the AMA, and of the American Heart Association.

EDITORIAL CRITERIA

CONTENT

NEW JERSEY MEDICINE is the official organ of the Medical Society of New Jersey. The goals are educational and informational. All material published is copyrighted by the Medical Society of New Jersey.

The educational contents of each issue appear as scientific articles, based on research, original concepts relative to epidemiology of disease, and treatment methodology; case reports; review articles; clinical notes; state of the art reports; and special articles, that include evaluations, policy and position papers, and reviews of nonscientific subjects. Other topics include professional liability commentary; critical narration; medical history; pediatric briefs; nutrition update; and opinions. Editorials are prepared by the editor and by guest contributors on timely and relevant subjects. The Doctors' Notebook section contains organizational and administrative items from the Medical Society of New Jersey and from the community. Letters to the editor and book reviews are welcome and will be published as space permits.

The principal aim in the preparation of a contribution should be relevance to diagnosis and treatment and to the education of patients and professionals. Preference will be given to authors from New Jersey and to out-of-state lecturers submitting a suitable manuscript based on a presentation made to an audience in New Jersey.

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The author should submit a 30-word abstract to be used at the beginning of the article.

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Illustrations should be professional quality, black-and-white glossy prints. The name of the author, figure number, and the top of the figure should be noted on a label attached to the back of each illustration. When photographs of patients are used, the subjects should not be identifiable or publication permission, signed by the subject or responsible person, must be included with the photograph. Material taken from other publications must give credit to the source.

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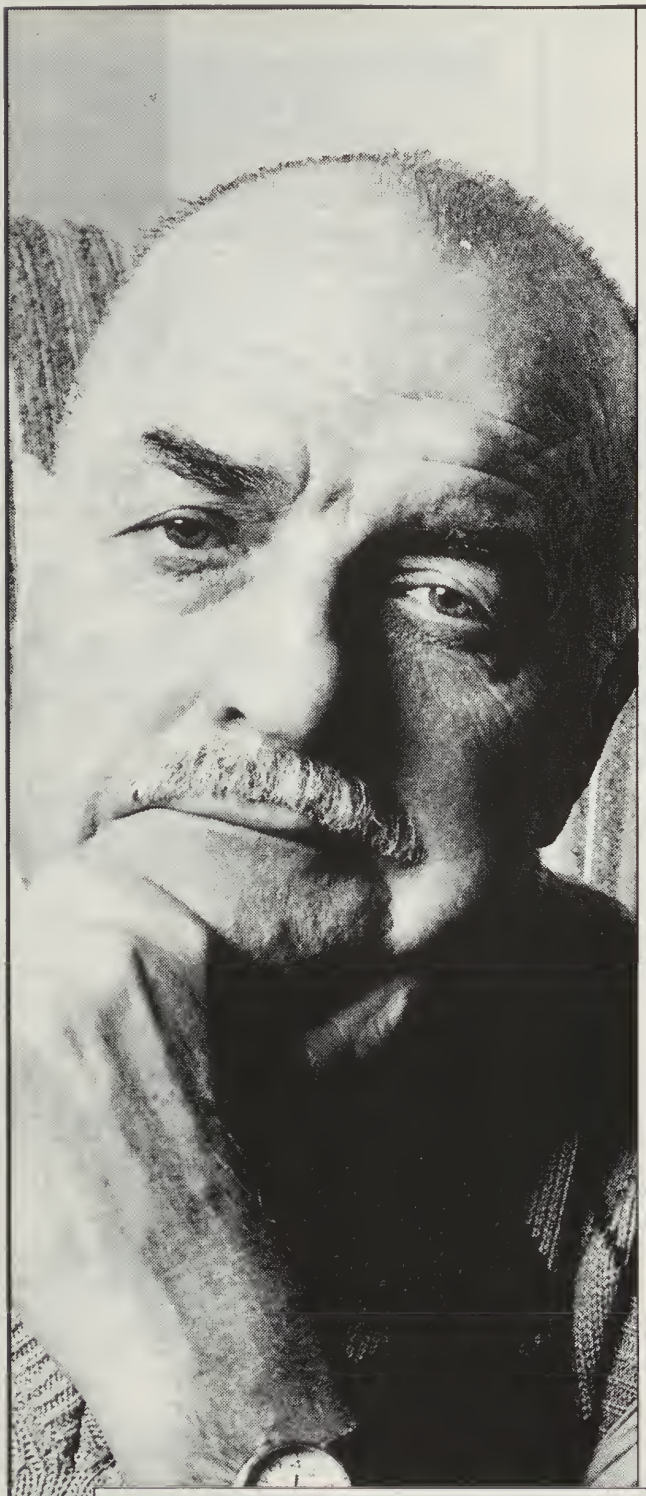
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1. Goldwyn RM: Subcutaneous mastectomy. *NJ MED* 74:1050-1052, 1977.

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The following is a brief summary only. Before prescribing, see complete prescribing information in Zantac® product labeling.

INOICATIONS AND USAGE: Zantac® is indicated in:
1. Short-term treatment of **active duodenal ulcer.** Most patients heal within 4 weeks.
2. **Maintenance therapy** for duodenal ulcer patients at reduced dosage after healing of acute ulcers.
3. The treatment of **pathological hypersecretory conditions** (e.g., Zollinger-Ellison syndrome and systemic mastocytosis).
4. Short-term treatment of **active, benign gastric ulcer.** Most patients heal within 6 weeks and the usefulness of further treatment has not been demonstrated.
5. Treatment of **gastroesophageal reflux disease (GERD).** Symptomatic relief commonly occurs within 1 or 2 weeks after starting therapy. Therapy for longer than 6 weeks has not been studied.

In active duodenal ulcer; active, benign gastric ulcer; hypersecretory states; and GERD, concomitant antacids should be given as needed for relief of pain.

CONTRAINOICATIONS: Zantac® is contraindicated for patients known to have hypersensitivity to the drug.

PRECAUTIONS:

General: 1. Symptomatic response to Zantac® therapy does not preclude the presence of gastric malignancy.
2. Since Zantac is excreted primarily by the kidney, dosage should be adjusted in patients with impaired renal function (see DOSAGE AND ADMINISTRATION). Caution should be observed in patients with hepatic dysfunction since Zantac is metabolized in the liver.

Laboratory Tests: False-positive tests for urine protein with Multistix® may occur during Zantac therapy, and therefore testing with sulfosalicylic acid is recommended.

Drug Interactions: Although Zantac has been reported to bind weakly to cytochrome P-450 *in vitro,* recommended doses of the drug do not inhibit the action of the cytochrome P-450-linked oxygenase enzymes in the liver. However, there have been isolated reports of drug interactions that suggest that Zantac may affect the bioavailability of certain drugs by some mechanism as yet unidentified (e.g., a pH-dependent effect on absorption or a change in volume of distribution).

Increased or decreased prothrombin times have been reported during concurrent use of ranitidine and warfarin. However, in human pharmacokinetic studies with dosages of ranitidine up to 400 mg per day, no interaction occurred; ranitidine had no effect on warfarin clearance or prothrombin time. The possibility of an interaction with warfarin at dosages of ranitidine higher than 400 mg per day has not been investigated.

Carcinogenesis, Mutagenesis, Impairment of Fertility: There was no indication of tumorigenic or carcinogenic effects in lifespan studies in mice and rats at dosages up to 2,000 mg/kg per day.

Ranitidine was not mutagenic in standard bacterial tests (*Salmonella, Escherichia coli*) for mutagenicity at concentrations up to the maximum recommended for these assays.

In a dominant lethal assay, a single oral dose of 1,000 mg/kg to male rats was without effect on the outcome of two matings per week for the next 9 weeks.

Pregnancy: ***Teratogenic Effects: Pregnancy Category B:*** Reproduction studies have been performed in rats and rabbits at doses up to 160 times the human dose and have revealed no evidence of impaired fertility or harm to the fetus due to Zantac. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

Nursing Mothers: Zantac is secreted in human milk. Caution should be exercised when Zantac is administered to a nursing mother.

Pediatric Use: Safety and effectiveness in children have not been established.

Use in Elderly Patients: Ulcer healing rates in elderly patients (65 to 82 years of age) were no different from those in younger age-groups. The incidence rates for adverse events and laboratory abnormalities were also not different from those seen in other age-groups.

AOVERSE REACTIONS: The following have been reported as events in clinical trials or in the routine management of patients treated with Zantac®. The relationship to Zantac therapy has been unclear in many cases. Headache, sometimes severe, seems to be related to Zantac administration.

Central Nervous System: Rarely, malaise, dizziness, somnolence, insomnia, and vertigo. Rare cases of reversible mental confusion, agitation, depression, and hallucinations have been reported, predominantly in severely ill elderly patients. Rare cases of reversible blurred vision suggestive of a change in accommodation have been reported.

Cardiovascular: As with other H_2-blockers, rare reports of arrhythmias such as tachycardia, bradycardia, atrioventricular block, and premature ventricular beats.

Gastrointestinal: Constipation, diarrhea, nausea/vomiting, abdominal discomfort/pain, and rare reports of pancreatitis.

Hepatic: In normal volunteers, SGPT values were increased to at least twice the pretreatment levels in 6 of 12 subjects receiving 100 mg q.i.d. intravenously for 7 days, and in 4 of 24 subjects receiving 50 mg q.i.d. intravenously for 5 days. There have been occasional reports of hepatitis, hepatocellular or hepatocanalicular or mixed, with or without jaundice. In such circumstances, ranitidine should be immediately discontinued. These events are usually reversible, but in exceedingly rare circumstances death has occurred.

Musculoskeletal: Rare reports of arthralgias.

Hematologic: Blood count changes (leukopenia, granulocytopenia, thrombocytopenia) have occurred in a few patients. These were usually reversible. Rare cases of agranulocytosis, pancytopenia, sometimes with marrow hypoplasia, and aplastic anemia and exceedingly rare cases of acquired immune hemolytic anemia have been reported.

Endocrine: Controlled studies in animals and man have shown no stimulation of any pituitary hormone by Zantac® (ranitidine HCl) and no antiandrogenic activity, and cimetidine-induced gynecomastia and impotence in hypersecretory patients have resolved when Zantac has been substituted. However, occasional cases of gynecomastia, impotence, and loss of libido have been reported in male patients receiving Zantac, but the incidence did not differ from that in the general population.

Integumentary: Rash, including rare cases suggestive of mild erythema multiforme, and, rarely, alopecia.

Other: Rare cases of hypersensitivity reactions (e.g., bronchospasm, fever, rash, eosinophilia), anaphylaxis, angioneurotic edema, and small increases in serum creatinine.

OVERDOSAGE: Information concerning possible overdosage and its treatment appears in the full prescribing information.

DOSAGE AND AOMINISTRATION: (See complete prescribing information in Zantac® product labeling.)

Active Duodenal Ulcer: The current recommended adult oral dosage is 150 mg or 10 mL (2 teaspoonfuls equivalent to 150 mg of ranitidine) twice daily. An alternate dosage of 300 mg or 20 mL (4 teaspoonfuls equivalent to 300 mg of ranitidine) once daily at bedtime can be used for patients in whom dosing convenience is important. The advantages of one treatment regimen compared to the other in a particular patient population have yet to be demonstrated.

Maintenance Therapy: The current recommended adult oral dosage is 150 mg or 10 mL (2 teaspoonfuls equivalent to 150 mg of ranitidine) at bedtime.

Pathological Hypersecretory Conditions (such as Zollinger-Ellison syndrome): The current recommended adult oral dosage is 150 mg or 10 mL (2 teaspoonfuls equivalent to 150 mg of ranitidine) twice a day. In some patients it may be necessary to administer Zantac® 150-mg doses more frequently. Dosages should be adjusted to individual patient needs, and should continue as long as clinically indicated. Dosages up to 6 g per day have been employed in patients with severe disease.

Benign Gastric Ulcer: The current recommended adult oral dosage is 150 mg or 10 mL (2 teaspoonfuls equivalent to 150 mg of ranitidine) twice a day.

GERD: The current recommended adult oral dosage is 150 mg or 10 mL (2 teaspoonfuls equivalent to 150 mg of ranitidine) twice a day.

Dosage Adjustment for Patients with Impaired Renal Function: On the basis of experience with a group of subjects with severely impaired renal function treated with Zantac, the recommended dosage in patients with a creatinine clearance less than 50 mL/min is 150 mg or 10 mL (2 teaspoonfuls equivalent to 150 mg of ranitidine) every 24 hours. Should the patient's condition require, the frequency of dosing may be increased to every 12 hours or even further with caution. Hemodialysis reduces the level of circulating ranitidine. Ideally, the dosing schedule should be adjusted so that the timing of a scheduled dose coincides with the end of hemodialysis.

HOW SUPPLIED: Zantac® 300 Tablets (ranitidine hydrochloride equivalent to 300 mg of ranitidine) are yellow, capsule-shaped tablets embossed with "ZANTAC 300" on one side and "Glaxo" on the other. They are available in bottles of 30 (NDC 0173-0393-40) tablets and unit dose packs of 100 (NDC 0173-0393-47) tablets.

Zantac® 150 Tablets (ranitidine hydrochloride equivalent to 150 mg of ranitidine) are white tablets embossed with "ZANTAC 150" on one side and "Glaxo" on the other. They are available in bottles of 60 (NDC 0173-0344-42) and 100 (NDC 0173-0344-09) tablets and unit dose packs of 100 (NDC 0173-0344-47) tablets.

Store between 15° and 30°C (59° and 86°F) in a dry place. Protect from light. Replace cap securely after each opening.

Zantac® Syrup, a clear, peppermint-flavored liquid, contains 16.8 mg of ranitidine hydrochloride equivalent to 15 mg of ranitidine per 1 mL in bottles of 16 fluid ounces (one pint) (NDC 0173-0383-54).

Store between 4° and 25°C (39° and 77°F). Dispense in tight, light-resistant containers as defined in the USP/NF.

September 1991

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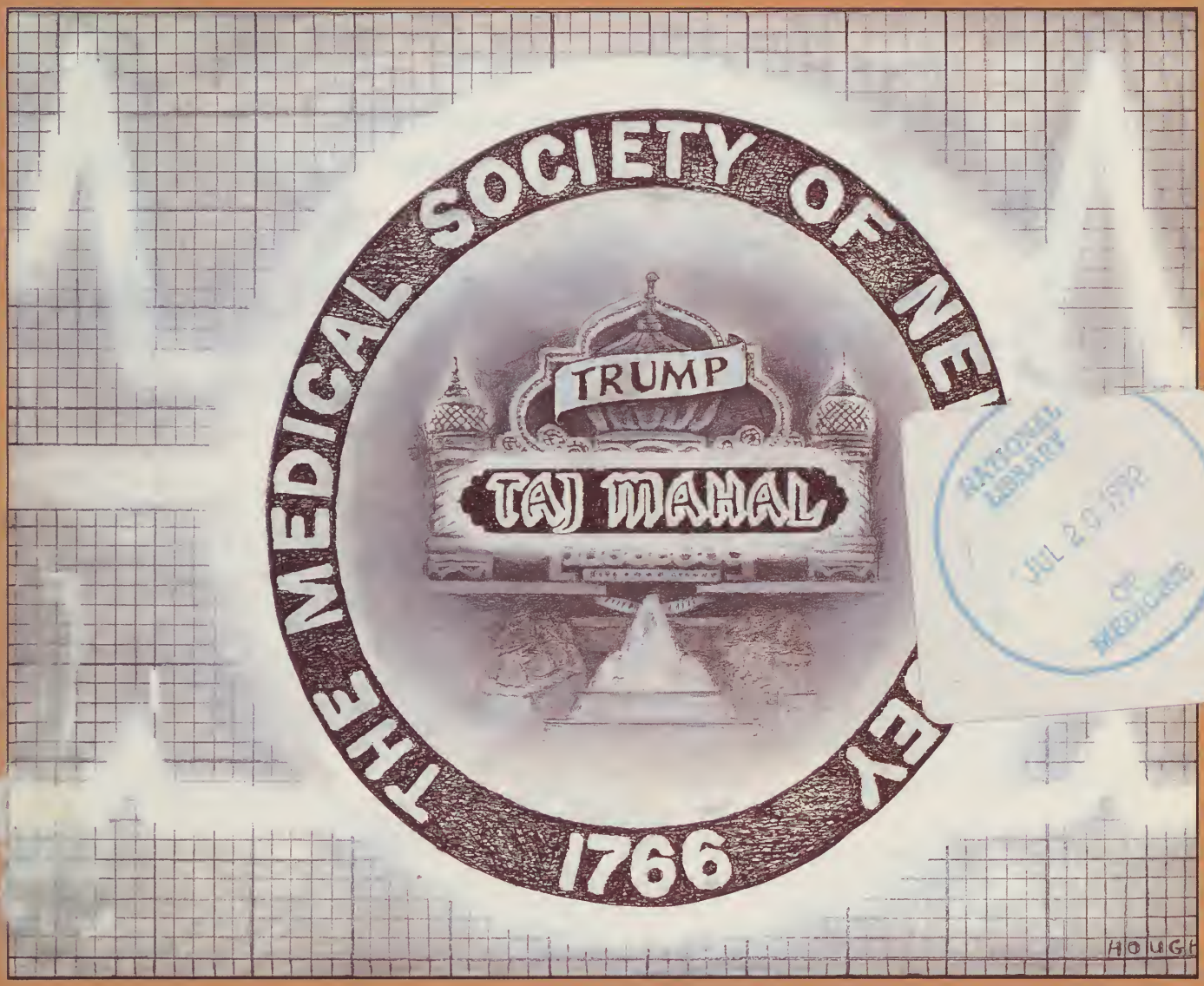

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Newswatch

HEALTH CARE FINANCING SYSTEM EXPECTED TO EMERGE...

A coalition, including the Medical Society of New Jersey (MSNJ), has been meeting to seek a solution to the state's uncompensated care crisis. Triggering the crisis was a May 27, 1992, decision in federal district court striking down most payments made to the state's Health Care Trust Fund.

Coalition members believe that the court decision effectively undermines the state's entire hospital rate-setting system, based on diagnosis related groups (DRGs). A market-oriented system is being sought to replace the regulatory approach articulated through DRG rate setting.

Other coalition members represent the state's hospitals, business, labor, third-party payers, and nurses. The effort commenced with development of a set of principles, agreeable to all participants, which could form the basis of a new system.

LEGISLATORS WRESTLE OVER STATE HEALTH PLAN...

On June 22, 1992, the fight over the Florio administration's State Health Plan moved to the state Legislature, as the Governor vetoed the bills, captioned A-1144/S-610, which would make the Plan advisory only. MSNJ, joined by the New Jersey Hospital Association, has been in the forefront of efforts to curtail the Plan.

MSNJ spokespersons argue that the Plan will not cut costs or improve access to care. MSNJ further contends that the Plan is a blueprint for a fully regulatory system, as the administration would have power to determine which hospitals provide which services.

The Health Care Administration Board adopted Phase 1 of the Plan as a regulatory package on June 18, 1992, after two months of extensive public comment. In a document submitted to the Board, the New Jersey State Department of Health (NJDOH) announced a softening of its original proposal to close six hospitals in the state and its acceptance of the "Medical Society's language change" on this point.

Various other changes proposed by MSNJ also were accepted, especially in the sections of the Plan addressing addictions and maternal and child health. In addition, NJDOH staff agreed to meet with appropriate MSNJ committees and task forces to discuss Phase 2 of the Plan, which will address primary care, surgical services, cancer, occupational and environmental health, injuries, diabetes, renal dialysis, and mental health.

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Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalmic centers and release of posterior pituitary hormone.

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indications: Yocon® is indicated as a sympathicolytic and mydriatric. It may have activity as an aphrodisiac.

Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

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Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.[1,3,4] 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to ½ tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.[3]

How Supplied: Oral tablets of YOCON® 1/12 gr. 5.4mg in bottles of 100's NDC 53159-001-01, 1000's NDC 53159-001-10 and Blister-Paks of 30's NDC 53159-001-30

References:

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2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical Letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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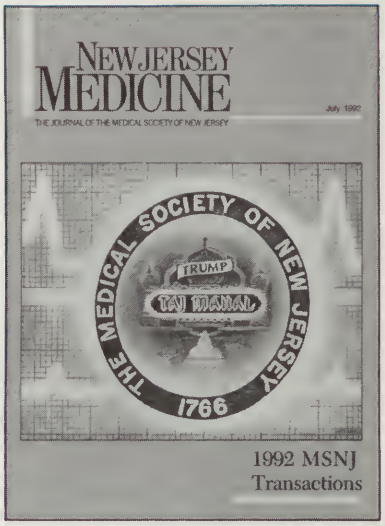
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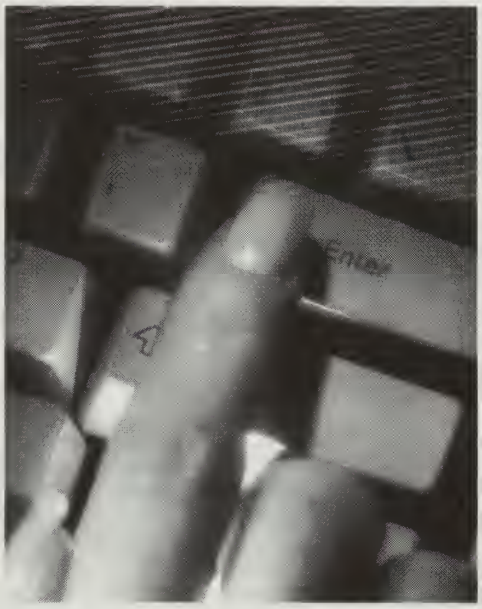
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MSNJ NEWSLETTER

CLINICAL LABORATORY IMPROVEMENT ACT: REMINDER

Federal regulations implementing the Clinical Laboratory Improvement Amendments (CLIA) of 1988 become effective on September 1. The statute extends federal regulatory authority to all facilities of any size that test human specimens. The Health Care Financing Administration (HCFA) estimates that as many as 130,000 physicians' offices where laboratory tests are performed will be affected by the law. While providers performing only simple tests such as dipstick/tablet urinalysis and urine pregnancy tests will be eligible for a waiver, every facility performing any testing on human specimens is required to complete the form HCFA-109, "Information To Implement CLIA of 1988." While more than 640,000 forms were distributed nationally in November 1991, some physicians may not have received the form. If you have the form, and you conduct laboratory tests in your office, complete it and submit it immediately. If you require a form, or you have any questions about the information requested, call HCFA's CLIA Hotline at 1/410/290-5850. All laboratories, regardless of the level of the tests they perform, must register with HCFA and demonstrate good laboratory practice.

SUPREME COURT DECISION ON SUPERVISION

In January 1989, the State Board of Medical Examiners (SBME) ordered the suspension of the license of a surgical facility's director of anesthesia based solely upon the acts of a nurse anesthetist working at the facility. The nurse anesthetist, without the knowledge of or consent of the physician, violated certain written policies of the surgical facility in one case. Yet it was undisputed that the anesthesiologist had no direct contact with the case and that none was required—it was a first trimester termination of pregnancy.

The Medical Society of New

Dear Colleague:

The American Health Legal Foundation, based in Tucson, Arizona, has initiated litigation against the United States Department of Health and Human Services to assure that physicians and Medicare beneficiaries may contract privately for physician services at fees above the limiting charge, provided that no bill is submitted to Medicare. The suit, captioned Stewart versus Sullivan, involves Lois J. Copeland, MD, of Bergen County, and five of her patients. The case currently is pending in the United States District Court in New Jersey.

On May 26, 1992, the House of Delegates of the Medical Society of New Jersey (MSNJ), during the 226th Annual Meeting of MSNJ, directed that an appeal for individual contributions to the Foundation be distributed to all MSNJ members to help finance this legal action. I am pleased to carry out this directive.

Please consider supporting Doctor Copeland's effort with a financial contribution. Contributions to the American Health Legal Foundation are tax-deductible as charitable gifts under section 501(c)(3) of the Internal Revenue Code. Checks may be made payable to "AHFL—Freedom of Choice," and may be sent directly to the American Health Legal Foundation, 1601 North Tucson Blvd., Suite 9, Tucson, Arizona 85716.

In addition, I would appreciate your thoughts about this matter—or any other issue affecting our membership at this time of unprecedented external pressure. Please feel free to write me at, MSNJ, Two Princess Road, Lawrenceville, NJ 08648.

Thank you. William E. Ryan, MD, President

Jersey (MSNJ) sought an opportunity to appear before SBME and present its opposition to SBME's position. SBME refused to even permit MSNJ's appearance. One might conclude that SBME, having made up its mind, had no desire to be confused by the facts. The Appellate Division of the Superior Court, initially, remanded the case back to SBME, finding that it failed to enunciate any specific failure by the anesthesiologist. Rather than accepting the fact and reversing itself, SBME created a novel theory. It found that the anesthesiologist had engaged in repeated acts of neglect by: "Contenting himself that based on his initial observations and the absence of negative comments from surgeons, that [the nurse anesthetist] was acting appropriately even though she might not have been meeting the standards that he himself met."

Subsequently, the Appellate Division sustained SBME's new finding, and the Supreme Court denied further review.

The lessons of this case are clear. The first lesson is that any effort by a facility or by a physician to provide greater care than the minimum required by law will be held to that higher standard. That lesson now is reflected in SBME's new corporate policy that requires every physician to prepare office policies and procedures. To the extent that these policies and procedures exceed the minimum required by law, however, the physician will be held to that higher standard.

The second lesson, and one that could have immediate and severe impact upon the delivery of health care in New Jersey, is that a totally innocent physician, who agrees to provide supervision to others as a public service to the community or to the hospital, can lose his license to practice medicine as a result of the unanticipated acts of those being supervised when those acts fall below the standards that the supervising physician meets. Under the present state of the law, physicians must be very careful about accepting any supervisory position at any health care facility. ☐ Steven I. Kern, Esquire

HEALTH RESOURCES DIRECTORY

The New Jersey Coalition for Consumer Education is offering a directory of more than 1,000 sources of free information and assistance involving addiction, family services, disabilities, senior citizen services, health services, and other resource areas. The fee is $12. Contact the Coalition at 434 Main Street, Suite 201, Chatham, NJ 07928, or call 1/201/635-2429; FAX 1/201/635-9526.

NEW MATERIAL ON ADVANCE DIRECTIVES

The state Biomedical Ethics Commission has produced a guidebook for health care professionals on advance directives. Written primarily for physicians, the guidebook contains 31 pages of text outlining suggestions for implementing new federal and state legislation, plus appendices. For a free copy of the guidebook, Medical Society of New Jersey (MSNJ) members are asked to contact Addie Holden at MSNJ headquarters, 1/609/896-1766.

"Directrices Anticipadas Para el Cuidado de la Salud" is the title of the first Spanish-language set of forms and information on advance directives. Copies may be obtained directly from the State Bioethics Commission, CN 061, Trenton, NJ 08625, with an enclosed self-addressed 9″ × 12″ envelope with $1 postage.

NEW PRESIDENT OF ACADEMY OF FAMILY PHYSICIANS

Lawrence A. Rosen, MD, a member of our Bergen County component and director of the Department of Family Practice,

Holy Name Hospital, was elected president of the New Jersey Academy of Family Physicians. The Academy promotes excellence in health care and provides advocacy, representation, and leadership for the specialty of family practice. Dr. Rosen maintains a private practice in Ridgefield, and is a member of Holy Name Hospital's Board of Trustees and its executive committee; in addition, he serves on the hospital's medical executive committee. He is a diplomate of the American Board of Family Practice, and is a clinical assistant professor of family practice at the University of Medicine and Dentistry of New Jersey-New Jersey Medical School. Dr. Rosen currently serves as vice-president of the Bergen County Academy of Family Physicians, and he is a member of the American Medical Association.

WASTE MANAGEMENT ENFORCEMENT

Fines of $3,000 are being levied against physicians who have failed to comply with Department of Environmental Protection and Energy regulations on waste management. For information call, 1/609/530-8599.

STAR AWARDS

Sue Binder, MD, director of the National Lead Program of the Centers for Disease Control (CDC) received the "Star Award" from the New Jersey Interagency Task Force on Prevention of Lead Poisoning, which had a star named after Dr. Binder. Dr. Binder was honored for her leadership in developing the CDC guidelines on lead poisoning in children that lowered levels from 25 ug/dL to 10 ug/dL and emphasized primary prevention efforts. Dr. Binder implemented the national lead poisoning prevention program that oversees programs in more than 30 states.

For statewide efforts to reduce the incidence of lead poisoning, the New Jersey Task Force on the Prevention of Lead Poisoning gave the "Star Award" to George Halpin, MD. Dr. Halpin was instrumental in continuing to screen New Jersey's children for lead under the Maternal and Child Health Block grant after the federal categorical lead program was abolished in the early 1980s. As a result of his efforts, thousands of New Jersey's children continued to be identified for and treated for elevated blood-lead levels.



Dr. Halpin (left) being honored with the "Star Award."

GROUND LEVEL OZONE AND ASTHMA

A substantial body of medical information links adverse respiratory effects with exposure to ozone. However, there is new medical evidence indicating that on days with high ground level ozone, hospital visits and admissions for asthma increase by 30 percent. Ozone appears to increase an asthmatic's responsiveness to allergens that trigger asthma attacks.

The American Lung Association estimates that there are about 300,000 New Jerseyans who suffer from asthma and the prevalence and severity of asthma has been steadily increasing. What is particularly disturbing is that deaths due to asthma have risen 30 percent, with 68 percent in urban minority populations.

Ground level ozone, the major component of smog, is a serious public health problem in New Jersey during the summer months. Sunlight acts photochemically on industrial and vehicular emissions to form ozone. It should be noted that ground level ozone ought to be distinguished from the ozone layer in the upper atmosphere, a naturally occurring ozone that is protective because it blocks harmful ultraviolet radiation from reaching the earth. High ozone levels occur on warm, sunny days typically between 11:00 AM and 7:00 PM. These also are the hours many people spend outdoors. Typically, 15 to 25 percent of the days from June through September have an ozone level over the federal health standard. However, in very bad years, as many as 60 percent of the days in some summer months have unhealthful levels of ozone.

The Department of Environmental Protection and Energy and the Department of Health will issue health bulletins when high ozone levels are forecast or measured. The New Jersey State Department of Health (NJDOH) recommends that whenever ozone reaches unhealthful levels, people limit physical activity outdoors, especially during the hours when ozone concentrations are highest.

Other unhealthful respiratory effects caused by ozone include: shortness of breath, chest pain, throat irritation, coughing, and wheezing in adults and children. Decreases in lung function have been observed in healthy exercising persons. These symptoms have been documented to occur at ozone levels typically measured in New Jersey during the summer.

Sensitive persons may include the young, the elderly, or those with pre-existing respiratory problems, especially asthma. However, clinical studies indicate that even healthy adults and children are likely to experience adverse health effects from ozone exposure when performing heavy exercise or manual labor outdoors at times when levels are high, usually in the afternoon.

For more detailed information on the health effects of ozone, contact Michael Berry, Environmental Health Services (EHS), NJDOH, 1/609/633-2043. Additionally, NJDOH/EHS has free copies of public-oriented materials on ozone, including: the ozone-asthma alert pamphlet, outdoor exercise and ozone exposure, and the ozone air pollution fact sheet.

Information on daily air quality forecasts can be obtained by calling the New Jersey State Department of Environmental Protection and Energy at 1/800/782-0160.

AIDS EDUCATOR RECEIVES GOVERNOR'S AWARD

AIDS researcher and educator Loretta Sweet Jemmott, RN, PhD, has received the 1992 Governor's Nursing Merit Award for Professional Advanced Practice. Dr. Jemmott, a faculty member of Rutgers University College of Nursing, is the first African-



Dr. Ryan and Dr. Jemmott

American to receive the honor.

Dr. Jemmott, a Princeton resident, was nominated for the award by the Medical Society of New Jersey. Medical Society President William E. Ryan, MD, praised Dr. Jemmott for "creating a new standard in the state for effectiveness and dedication in AIDS prevention."

Dr. Jemmott is co-chairperson of the Education and Prevention Committee of the Governor's Advisory Council on AIDS. She received her doctorate from the University of Pennsylvania.

The award recognizes "excellence in clinical care skills, leadership practices, nursing management, research, education, and health policy development." Sharing the award with her is Mary Ann Fralic, RN, DrPH, senior vice-president at Robert Wood Johnson University Hospital in New Brunswick.

LOAN REDEMPTION PROGRAM

Included in the Health Care Cost Reduction Act of 1991, the Loan Redemption Program provides for its participants the redemption of eligible student loans in exchange for specified periods of service in medically underserved areas. In New Jersey, these areas include Atlantic City, Camden, Paterson, Newark, Trenton, East Orange, Jersey City, and Plainfield. An applicant must be a resident of New Jersey; must have completed an accredited residency in internal medicine, general pediatrics, family practice, or obstetrics and gynecology; and must secure letters of recommendation from faculty members. A participant may redeem up to $70,000 of eligible student loans and expenses. To receive an application and further information contact, William S. Vaun, MD, Loan Redemption Program, Administration Complex 119, 30 Bergen Street, Newark, NJ 07107-3000.

URINARY INCONTINENCE ADDRESSED

As part of a new program to issue guidelines for medical care, the United States Agency for Health Care Policy and Research produced a guideline entitled, "Urinary Incontinence in Adults" and an accompanying patient guide. Both are available free of charge from AHCPR Publications Clearinghouse, P.O. Box 8547, Silver Spring, MD 20907, telephone 1/800/358-9295.

According to federal authorities, more than ten million Americans are experiencing urinary incontinence but are not informing their physicians—even though 80 percent of the cases may be managed successfully. □

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PROFESSIONAL LIABILITY

HEALTH CARE FINANCING

Vermont plan. Led by new Governor Howard Dean, MD, Vermont now is pioneering in state-run health insurance. Legislation in the Green Mountain State charges a three-member commission with the job of designing a system of universal access, presumably involving a single payer. The act also includes support for alternative dispute resolution to reduce liability costs. The young, photogenic Dean may be a comer in national politics. Recognizing his role in state health reform, organizers of the 1992 Health Policy Forum in Washington, DC, chose him as a luncheon speaker.

Minnesota plan. Governor Arne Carlson's Health Right plan in Minnesota establishes a health care fund for the uninsured with premiums based on a sliding fee scale and funding based on taxation of hospitals, physicians, other providers, insurers, and purchasers of cigarettes. Starting in 1994, under the law, physicians in the Gopher State will be paying a 2 percent levy on private pay revenue.

Under pressure from the Minnesota Medical Association (MMA), the bill was changed to replace a comprehensive certificate-of-need requirement for new technologies with a mandate to report capital expenditures exceeding $500,000. The law, enacted on April 23, creates a 25-member commission, including one MMA representative, to recommend spending limits.

Florida plan. Governor Lawton Chiles, a former U.S. senator known for his advocacy of child health issues, has signed extensive legislation giving Florida's health care system two years to attain universal coverage through voluntary means or else face a state takeover of the health insurance system on January 1, 1995. Other features of the Sunshine State law include: creation of an agency for health care administration with comprehensive authority over matters ranging from payment to licensure; development of practice parameters to rationalize malpractice liability; and the establishment of a reinsurance pool and standard insurance package to encourage small employers to provide health benefits.

California proposal. California's insurance commissioner is advocating payment reform based on managed care. John Garamendi's proposal would provide Californians with typical HMO benefits funded through a 1 percent payroll tax. All health-related insurance coverage, including worker's compensation and automobile related benefits, would be consolidated.

American Hospital Association proposal. The American Hospital Association's new president, Richard J. Davidson, is promoting state-based capitation as the most reasonable method of financing universal health coverage. Community health networks would be responsible for providing the care; hospitals' leadership of the networks is the main advantage to the hospital industry. A national panel would define minimum benefits, and expenditures would be controlled by Congress through a biennial budget.

Internists' proposal. The American Society of Internal Medicine (ASIM) has issued a proposal that uses resource-based relative value scales (RBRVS) as the basis for controlling na-

Figure. ***CLIA regulation of physician office laboratories.***

Lab Level	Tests Performed	Director Training	Fees	Inspection
Waivered	Blood glucose, hemoglobin, ketones, urine pregnancy, etc.	No specialized training required	$100	No periodic inspection
Moderate complexity	Most fully automated specialty tests	One year of experience or 20 CME hours	$400-$3,715	Biennial
High complexity	Analyzed tests, e.g. cytogenetic, histopathology, cytology, histocompatibility	Two years of experience or one year training in residency	$400-$3,715	Biennial

tionwide health expenditures. Under the plan, ASIM and other specialty societies would negotiate with a national panel to adjust RBRVS fees and conversion factors among specialties.

CLIA update. Three levels of physician office laboratories are recognized under new Clinical Laboratory Improvement Act (CLIA) regulations, which take effect September 1, 1992. Differences in regulatory oversight are summarized in the Figure.

Fees for complex laboratories vary according to volume and the number of hours required for inspections. Moderate complexity laboratories—that include most of the nation's 130,000 facilities—are subject to requirements for quality assurance and recordkeeping. High complexity laboratories face additional controls for personnel, management, and proficiency testing.

Physicians who have not received or paid their bill for registration are advised to contact the Health Care Financing Administration and register, buying time before deciding whether to continue to perform laboratory functions. Withdrawals from the laboratory market due to CLIA requirements could create market opportunities for those physicians who remain, advises consultant George Conomikes in the May 1992 *Conomikes Medicare Hotline.*

MALPRACTICE POLICY DEVELOPMENTS

Why parents sue. Motivations for suing for malpractice by defective newborns' parents were explored in a Florida study recently reported in *Medical Liability Monitor.* Based on lengthy telephone interviews, Vanderbilt University researchers identified failed expectations, suspicion of coverups, frustration at receiving insufficient information, anger, revenge, and a desire to prevent harm to others as reasons for bringing suit. Pecuniary motives also played a part, especially with regard to the need to finance continued care of the child.

Suing your utilization review agency. Parents sued Blue Cross of California, another insurer, and a utilization review (UR) firm after their son died following a UR-prompted hospital discharge. In April, a jury found that Blue Cross acted in bad faith but without malice, so that damages were not awarded. What is portentous, though, is that the trial was held; an appellate court earlier had overturned the trial court's dismissal of the case. And, in a different case involving a Medi-Cal recipient, the state Court of Appeals provided dicta that "third-party payers of health care services can be held legally accountable when medically inappropriate decisions result from defects in the design or implementation of cost containment mechanisms."

The malpractice liability chain ultimately may extend past reviewers and payers to employers who provide coverage. As that happens, business may become an even stronger champion of tort reform.

Suing your nursing home. For the past 25 years, hospitals in the United States have faced liability for medical malpractice, while nursing homes generally have eluded successful claims. But, recent verdicts, especially following a landmark 1990 Mississippi case, are jeopardizing nursing home owners' complacency.

What had saved nursing homes were the low amounts recoverable for lost earnings, medical expenses, and other damages sustained by their frail elderly residents, plus plaintiffs' difficulties in proving neglience in a totally controlled environment where the victim was confused and inarticulate. Now, as explicit standards of care emerge and require documentation, more and more successful claims are anticipated for injuries involving falls, wandering, the use of restraints, and the failure to use restraints.

Alliance for reform. Alliance for Medical Liability Reform is being organized by the American Medical Association in order to press for legislative relief from tort liability. Members include the Washington Business Group on Health, National Association of Manufacturers, and the American Hospital Association.

$90 million award. In Manhattan, a jury has awarded more than $90 million to a child for neurologic injuries sustained at birth. Just before trial, the defendant hospital rejected a $3 million settlement offer. The child, now 14, was said to require daily physical therapy and round-the-clock nursing assistant care for the rest of her life. Her life expectancy was 79 years. Allegations included failure to diagnose and treat respiratory distress syndrome, and negligent neonatal care resulting in hypoxia and cerebral palsy.

Premium rates are holding. *Medical Liability Monitor's* latest survey of 39 physician-owned underwriters revealed that at least half are keeping their premiums steady in 1992. Rate reductions were most common for general surgeons.

Median premium rates were $6,074 for internists not performing invasive procedures, $22,758 for general surgeons, and $40,068 for obstetrician-gynecologists. The ranges for these three specialties were wide, however, and rates were highest in urban areas in Florida, Illinois, Michigan, and New York. New Jersey's Medical Inter-Insurance Exchange showed premiums 20 percent higher than the median for the internists, 5 percent lower than the median for general surgeons, and 29 percent lower than the median for obstetrician-gynecologists. The Medical Inter-Insurance Exchange recently lowered its rates to anesthesiologists by 20 percent.

Cap on pain and suffering.

Maryland's Court of Appeals has upheld a cap on noneconomic damages and reduced a jury award to $350,000 in a case involving an automobile collision. The court rejected a claim that the legislated cap violated the equal protection clause of the state constitution. The cap, said the court, constituted economic legislation, and, therefore, a rational-basis test, rather than strict scrutiny, should be used in the equal protection analysis.

Also rejected in the case was a claim that the cap violated the right to trial by jury. The court said that the constitution's jury trial clause addressed the allocation of responsibility between judge and jury, and not the Legislature's right to limit causes of action.

Update on brotherly fraud. In Trenton, on April 27, 1992, one of two brothers charged with fraud, money laundering, and conspiracy involving malpractice insurance pleaded guilty in federal court—in the middle of a trial. The Perry Mason finish, in which a partner of the convicted brother also pleaded guilty, was not really the end, however, as charges of extortion in the sale of malpractice insurance to a group of 60,000 nurses still were pending. Earlier, another partner pleaded guilty in Newark and agreed to testify against the brothers Bramson.

AIDS ISSUES

Disabilities Act and AIDS. The new Americans with Disabilities Act prohibits discrimination in public accommodations "on the basis of disability." The language of the act makes clear that physician offices are public accommodations for purposes of enforcement, and that disability includes impairment, or perception of impairment, "that substantially limits one or more of the major life activities" of an individual. To the authors of *Medical Malpractice Reports,* this makes it "possible to argue that a physician or dentist who refuses to provide treatment for HIV-positive persons out of fear of the disease or its effect on his or her business is in violation of federal law."

However, an HIV-positive person who is denied treatment from the start has no cause of action for abandonment. Liability for abandonment occurs only when the physician terminates existing care at a crucial stage of treatment, without reason or notice sufficient to obtain care from another practitioner, and, thereby, causes injury to the patient.

MALPRACTICE AND OTHER CASES

Time limits on suing for increased risk of harm. One year after a physician advised a patient that a mole on the patient's lower back was an insignificant fatty cyst, a biopsy disclosed that the mole was malignant melanoma and it was excised. Two years later, the patient sued but withdrew his suit in the belief that he still had better than a three-in-four chance of surviving for 7½ years.

Three years after the suit was withdrawn, metastatic malignant melanoma was observed in a nodule adjacent to the surgical site. Now, according to an expert opinion, the patient's chances of survival plummeted to 30 percent. He and his wife sued for an increased risk of harm resulting from the original year's delay in diagnosis, but a judge ruled that the suit was barred under the statute of limitations due to the five-year lapse between the surfacing of the error and the filing of the second suit.

Reversing the dismissal, a three-judge panel in the Appellate Division of New Jersey's Superior Court held that a cause of action for increased risk of harm accrued only after the finding of metastatic cancer. Only then, said the appellate court, did death become a "reasonably probable" outcome. A concurring opinion suggested that a better procedure would be to permit a plaintiff, on withdrawing an original suit for increased risk of harm, to make discovery and file pleadings but defer a trial until the adverse outcome became probable.

MALPRACTICE VERDICTS

Extensive scarring. A pea-sized lesion of fibrous tissue was excised from the pre-sternal area of a young adult woman. Four months later, a general surgeon excised the surgical scar. Keloids developed, causing a scar less than four cm by four cm in size. More than two years after the simple incision, another general surgeon performed a wide excision with a full thickness skin graft, using tissue from the forearm. The resulting scar was nine cm long at its longest point, four cm wide at its widest point, and elevated at its rim. The patient settled with the first general surgeon for $75,000 and brought the second surgeon to trial in New Jersey.

The plaintiff contended that the final operation was contraindicated in light of the previous scarring. The defendant claimed that he had advised the patient that the procedure could aggravate the condition. The parties also disputed whether use of the forearm was reasonable; scarring developed there, too, but the defendant said that the forearm provided the desired skin color.

The plaintiff claimed she suffered substantial loss of self-esteem as a result of the scarring. She appeared withdrawn when the issue of damages was discussed in court, and produced photographs showing the scar. The plaintiff also demonstrated that the surgeon had been unemployed for extensive periods and lacked supervised surgical experience. The jury's verdict was for $750,000.

Nursing home liability. Eleven times during a 13-month period, a confused and disoriented nursing home resident fell. The resident used a wheelchair for mobility and convenience, although he could ambulate somewhat. Physician orders for several months included physical restraints as needed in the absence of direct supervision; these orders were softened but generally still in effect on Christmas Eve as the resident sat in a solarium while nurses distributed food trays. The resident attempted to rise from his wheelchair to go to the bathroom, fell, and fractured his hip. When the resident's son arrived to take his father on a home visit, he was told that his father was asleep. Seven weeks later, the resident went into cardiac arrest and died.

In a suit against the nursing home for malpractice, the plaintiff provided scientific articles suggesting that cardiac arrest soon after a hip fracture in a patient without heart disease probably resulted from the trauma. Evidence also was adduced that the nursing home previously had removed the resident's nurse call bell due to excessive use. The New Jersey jury found that the fall was a proximate cause of death and awarded $19,209 for medical expenses, $25,000 for pain and suffering in the nursing home prior to the fall, $50,000 for pain and suffering after the fall, $50,000 for loss of enjoyment of life after the fall until death, and zero for wrongful death.

MALPRACTICE TIPS

Pediatric head injuries. Each year approximately 95,000 pediatric head injuries are presented to emergency departments in the United States. According to abstracts summarized in *Personal Injury Newsletter,* patients who lose consciousness for more than five minutes, have lowered levels of consciousness, have focal neurologic findings, or present depressed or penetrating skull injuries with signs of basilar damage are at greatest risk of intracranial injury. Children younger than age two are at particular risk due to developmental immaturity of the skull and brain even in the absence of a skull fracture.

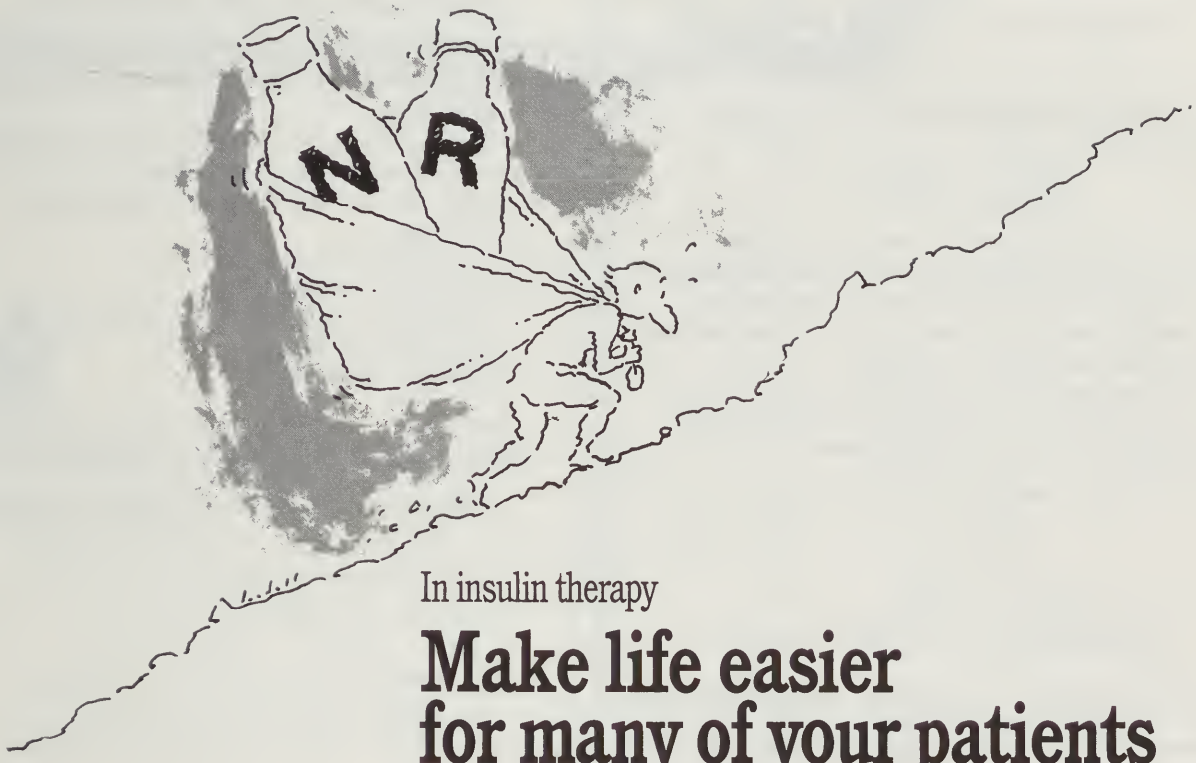
Linear fractures in the parieto-occipital region, a frequent indicator of child abuse, and diastatic fractures can cause cerebrospinal fluid-containing cysts that can prevent fusion of the fracture margins and are associated with neurologic dysfunction. Early diagnosis of skull fractures in young children is extremely important.

ANTITRUST

AMA seeks self-regulation. Power for physician groups to negotiate third-party payment, freedom for separate physician practices to market their services jointly, and authority for organized medicine to regulate professional advertising are sought by the American Medical Association (AMA). On April 30, 1992, the AMA asked the Federal Trade Commission to relax its strict interpretation of antitrust principles as applied to the medical profession.

BIOMEDICAL ETHICS

International conference. Toronto on July 19 to 23, 1992, will be the scene for the Third International Conference on Health Law and Ethics, sponsored by the American Society of Law and Medicine (ASLM). Sessions will address HIV issues, women's health, national health systems, and other issues. Contact ASLM Conference Travel Planners, Suite 150, GNM Building, San Antonio, Texas 78216-5674, telephone 1/512/341-8131, FAX 1/512/341-5252. □ James E. George, MD, JD; Neil E. Weisfeld, JD, MsHyg



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BOOK REVIEWS

AIDS AND THE LAW. 2ND EDITION

Wiley Law Publications Editorial Staff. New York, NY, John Wiley & Sons, Inc., 1989. John Wiley & Sons, Inc. has put together the second edition of *AIDS and the Law,* a 500-page book with a legal-type red cover. The authors are attorneys from prominent law firms and universities in the United States. A few scholarly physicians also contributed to the text. David W. Webber, executive director of AIDS Law Project of Pennsylvania, termed this "AIDS Law," and said this epidemic will test the compassion of our legal system.

The book covers HIV background, AIDS in the workplace, educating children and the family, life insurance, confidentiality issues, jails, and many other pertinent issues.

This book is an excellent reference manual, written and annotated in legal style. HMOs would appreciate page 297 and the effect AIDS has on these centers. The book covers topics such as blood banking legal problems including blood components; informed consent, a problem all doctors have regarding needle sticks, operations, and blood donations; and assault and battery when an HIV-positive person engages in sex with an innocent victim.

AIDS has changed our lives forever, medically and legally. This book is a good start in this continuing process, while AIDS kills 20 million people worldwide. ☐ Leon G. Smith, MD

ETHICS AT THE BEDSIDE

Charles M. Culver, MD, PhD. Hanover, NH, University Press of New England, 1990. Ethical dilemmas in medicine and the role of ethics committees as resources to assist in dealing with such dilemmas have captured the spotlight in medical affairs. Reasons for this include the increased sophistication of medical technology and medical treatment, and questions about the appropriate utilization of such procedures as organ transplantation and life support measures. In addition, patients and families are becoming more assertive in making decisions regarding treatment. Physicians are learning that management decisions they make may not necessarily be entirely "medical." For example, the decision to administer cytoxic chemotherapy to a cancer patient may depend not so much on whether a response may be achieved as whether or not the patient is willing to undergo the rigors of treatment, considering its often limited benefit.

Physicians and other health care workers deal daily with the perplexing issues raised in connection with the application of new medical technologies. Dr. Culver's book focuses on these dilemmas and points out the importance of the ethics consultation process as an aid to resolving them. Twelve powerful vignettes are presented. Each emphasizes the potentially helpful process of "hands-on" ethics consultation.

Among the scenarios described in this emotionally engaging and thought-provoking book are: assisting a family to recognize the inevitability of death of a loved one and to provide realistic alternatives to unnecessary or inappropriate care; providing insight into the complex ethical issues related to withdrawal of life

support to gravely ill or seriously handicapped neonates; and dealing with disagreements among family members and even physicians with regard to treatment decisions.

Issues examined in this book include the moral distinction between active and passive euthanasia, the importance of a living will or durable power of attorney for health care, the physician's use of a "benefit or burden" rationale when deciding on treatment, and weighing the quality of life versus the length of life.

This book will be useful for physicians, other health care workers, patients, families, and persons concerned about compassionate, sensitive, sensible medical care. ☐ Alan J. Lippman, MD

NEOPLASTIC DISEASES

C. Julian Rosenthal. Chicago, IL, Precept Press, 1991. Many fields in medicine have undergone tremendous growth and maturity. Few specialties have become as complex and remain as challenging as neoplastic diseases. This book, although nearly 900 pages, presents a thorough overview of clinical oncology as it exists today.

The book, *Neoplastic Diseases: Fundamentals of Clinical Oncology,* is especially useful to postgraduate students in oncologic and nononcologic fields and to family physicians caring for cancer patients. Fifty contributors have assisted the editor in providing clinicians and researchers with the current developments in pathogenesis, diagnosis, and treatment of neoplastic disorders. The subject matter is well organized and logically presented and a detailed index helps the reader quickly find information. A clearly written text is supplemented by two comprehensive atlases, one atlas presenting the histopathology of malignant tumors (18 pages in full color) and the other atlas presenting diagnostic imaging.

A full range of subjects is considered, from the epidemiology of cancer through viral carcinogenesis, oncogenes, tumor growth kinetics, and the genetic and biochemical factors that underlie cancer biology. There is a chapter dealing with the common metabolic disturbances that affect cancer patients and additional chapters dealing with the physical and radiobiologic basis of radiation therapy and the principles of chemotherapy. Psychological disorders in cancer patients also are considered. A series of chapters deals with specific neoplastic conditions and the entire work is supplemented with a separate removable compendium of regimens and schedules of administration of combination chemotherapy and supportive therapy. This 42-page removable section fits conveniently in laboratory coat pockets.

This work fills an important void for those wishing to get a "handle" on the immense complexities that characterize the study of neoplastic conditions. ☐ Alan J. Lippman, MD

THE RIGHT TO DIE

Alan Meisel. New York, NY, John Wiley & Sons, Inc., 1989. Alan Meisel, professor of law at the University of Pittsburgh, has edited a scholarly 572-page reference book on the right to die, for lawyers, doctors, and ethics leaders. The text examines substantive aspects of the right to die, ethics committees, living wills, immunity, legal liabilities, and medical staff versus institution committees, and many other topics.

The first right-to-die case was New Jersey's Quinlan case, decided by the New Jersey Superior Court in 1976. The first significant legislation occurred in California, also in 1976. Public at-

titudes as well as medical attitudes have changed immensely since that time as has health care terminology. The basic principles of medical decision making are not very complete, but the quality of life discussion on page 461 is extremely valuable for handling child abuse problems.

For hospitals, chapter 15 offers fine suggestions on ethics committee organization, functions, and legal liabilities.

This is not easy reading, but represents a fine reference book. Overall, this book is a must for medical and law libraries. ☐ Leon G. Smith, MD

SELECTED TOPICS IN THE CLINICAL SCIENCES

William P. Creger; Cecil H. Coggins; E. William Hancock. Palo Alto, CA, Annual Reviews, Inc., 1992. This annual "meta-narrative" distinguishes itself by its timely topic selections and clinically friendly prose. The menu for this informational Festschrift appeals primarily to the clinical scientist while simultaneously providing fare for the primary care physician. Authorship was through invitation by the editorial committee of Annual Reviews, Inc., whose board chairman is Joshua Lederberg, 1958 Nobel Prize winner and Rockefeller University professor.

The content of *Annual Review of Medicine: Selected Topics in the Clinical Sciences* is well organized and identified by chapter, title, author, and index with cross reference to related articles in companion reviews. Copious subject references are provided. Paper and typeset quality are acceptable. Illustrations are austere but appropriate. Abstracts precede each chapter.

High-technology mavens will find state-of-the-art developments in the application of cytogenetic/biochemical principles in the diagnostic laboratory and elucidation of some disease states. Diagnosis and therapy in primary care also are addressed.

"Valeat quantum valere potest." (Let it pass for what it is worth.) ☐ P.A. Ruggieri, MD

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LETTERS AND VIEWPOINTS

OBSERVATIONS

During the recent Passover services, I observed a male relative, 80 years old, with Alzheimer's disease progressing for at least 3 years. He stopped talking four months ago and had done some wandering last year until closer observation was started; he had no delusions or paranoia. When it came to singing with the group, a pleasant old refrain, known since childhood, he joined in the singing—although he had not spoken before or again during the evening. This refrain is a repetitive lively chorus, translated into English as "we are grateful," but in Hebrew a single word "dayenu" sung repeatedly, which he did in the proper melody and timing along with all of us—smiling and enjoying it—and then remained silent all evening, not even "goodnight" on leaving.

In contrast, I have a patient, a diabetic man, 78 years old, with a gangrenous leg removed, a previous hemiplegia with residual spasticity, and parkinsonian tremor. He became aphasic although he occasionally would hum notes out loud or cry out, as if from boredom. His daughter (the caregiver) and I observed that although he did not speak words, if frustrated or annoyed by interruption in feeding his voracious appetite, he would begin to curse, which he probably had learned early in life. This is a patient with multi-infarct dementia who could curse, compared to one with Alzheimer's disease who could sing, but both men did not talk.

In an early Alzheimer's patient, it is known that early patterns and memories are retained while the last five minutes of instructions may be forgotten and this alone might not be reason enough to write. However, we note that none of the mental state examinations or depression versus dementia examinations test for whether or not the patient can sing.[2] The most popular test for dementia, the Folstein Mini-Mental State Examination, does not question it.[3]

Patients who have one pathway impaired, therefore, may have an emotion-linked bypass-drive that invites our inquiry. Is the patient "locked in" with singing or cursing as his only outlet remaining? Does the extra emotion enable him to overcome a biochemical threshold deficiency?

When the family sees that the patient can sing, they are gratified to treat the patient more like a person, and less like a "vegetable" or "has been," a point not mentioned before in our reading but a significant motivation in family care by the physician.

Physicians who examine the elderly might readily ask a patient if he will "sing along with me" a few lines of a familiar tune. Our good intentions may fail, however, because there is a difference between spontaneous inner responses, and trying to get through to the patient to sing intellectually what he does not feel at the moment.

If we can show that the patient who can sing or curse has more will to live, it might become a useful tool. There is an old Hebrew saying, "A people that lives, sings. A people that sings, lives." Can this be extrapolated in care for the elderly? Is it a clue that the self's integrity remains? Does music have charm not only to soothe but to identify "a savage beast" within us?

Let us add a line to the complete examination of the demented: Does the patient sing or curse in response to a familiar or appropriate stimulus, when he feels like it?

Family physicians, psychiatrists, geriatricians, and history-takers par excellence—please take note. □ Morris Soled, MD

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2. Cadieux RJ: Early differentiation of senile dementias. *Hospital Practice* 77-94, 1989.

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Editor's note. We are somewhat surprised not to see the name of Oliver Sachs in the references. We recommend his books to the reader.

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EDITOR'S DESK

CONFLICTS

At the time of this writing, May 30, 1992, one of the headlines in the *American Medical News (AMN)* read, "AMA, state society on opposite sides." The story started, "The Medical Society of New Jersey (MSNJ) is supporting a physician's right to 'self-refer,' a position officials say does not back American Medical Association (AMA) policy. But AMA officials say that the Society's stance could determine the medical profession's efforts to police itself."

The action of MSNJ occurred on May 5, 1992, during the final session of the Annual Meeting of the House of Delegates. It represented one of the final gasps of a dying session, but also provided the most spirit and argument of the entire meeting. Debate was most appropriate, for the ethics, or lack thereof, portrayed by the opposing sides and the final decision by the House put the medical profession in a no-win situation—in an internal squabble.

The position of MSNJ, which flew in the face of AMA policy adopted in December 1991, mirrored the position of New Jersey legislators; MSNJ delegates were agreeing to comply with state law. But New Jersey law is less stringent than AMA policy, which reflects the moods of doctor-bashing legislators like Representative Fortney (Pete) Stark of California. Is the policy of the AMA based purely (sic) on moral and ethical considerations or is it a modern-day Munich—appeasement with Chamberlain–like hopes of averting total war against governmental forces? Or is it a negotiating ploy? Or is it evidence of a new AMA attitude, also seen in the tough AMA stance toward gifts, which outstrips the Food and Drug Administration in its austerity and restrictions?



Howard D. Slobodien, MD

The *AMN* article continued, "Although physician investment in health facilities can benefit patients, the practice poses a potential conflict of interest." Ay, there's the rub—conflict of interest, a concept debated for millenia and still unsolved. There is no doubt that many abuses have occurred, as reported from the Southeast. They are despicable, deplorable, and dastardly. But it is impossible to avoid conflict. When a private practitioner decides on the frequency of patient visits, he is in a potential conflict situation. If he has a fee-for-service practice, he risks self-interest by offering too many services to the patient. If he is a gatekeeper in a capitation plan, the opposite applies; fewer services equals more revenue. Can any for-profit health care entity—whether private practitioner, salaried physician of a HMO, PPO, or hospital, or whatever—avoid a conflict of interest? Can any salaried employee, even one employed by a nonprofit or governmental agency, avoid similar conflicts? The answers are obvious.

At a certain point integrity must be allowed to play a major role when considering potential conflicts of interest. Unfortunately, belief in integrity is in short supply in today's world and it continually diminishes, at least in people's eyes. The behavioral offset applied by the Department of Health and Human Services and the Health Care Financing Administration to Medicare fees is a prime example of such mistrust. Once again, we have the pot calling the kettle black. Governmental workers, with morality compared to the much-maligned used-car salesman, continue to impugn the ethics of physicians. If such abuse continues and the medical profession is powerless to resist the tarring and feathering by governmental agents, the percentage of physicians who subvert their basic good will must increase, because some well-meaning but disgusted doctors will feel they might as well be "hanged as sheep rather than as lambs."

We have received letters from colleagues who decry self-referral as an atavistic return to fee-splitting days. The writers' arguments are identical to those expressed on the floor of the House of Delegates at our meeting in May. They are powerful arguments; but they are diluted because the protagonists are members of a medical specialty that tends to be in direct competition with those criticized for investing in joint ventures. Thus, the accusation of "conflict of interest" by these correspondents reminds us of the old

child's refrain, "I'm rubber and you're glue; bounces off me and sticks to you." As we noted in these pages, this internecine carping and criticism weakens the medical profession and makes us easier prey for the piranhas nibbling at our flanks.

When this appears in print in the Transactions issue, the New Jersey position will have been debated on the floor of the House of Delegates of the AMA. No good is likely to come from it. The MSNJ resolution will ask the AMA House to reconsider its stand. This may have posed an unresolvable situation. If our resolution is approved, many will feel that the medical profession is reneging on its ethical standards. If the AMA policy prevails, not only does MSNJ lose the debate, but present governmental regulations can be expected to proliferate and become even more restrictive. It probably is too much to hope that a final decision will be deferred and the entire matter will be reconsidered, particularly if the medical profession could be granted reasonable policing powers over its own members, as many of us, and the AMA, would prefer. Even Ann Landers would applaud. Regardless of result, the dilemma remains.

Your attention is directed to other business reported in the Transactions and to other items in this issue related to smoking. The House approved a resolution asking that pharmacy groups take steps to have retail pharmacists remove tobacco products from their shelves. The article on smoke-free areas in restaurants and the special editorial on the same subject continue as one of our pet projects, publicizing the danger of both active and passive smoking. The evidence supporting our stand continues to mount. We have come a long way. The smoker now is a member of a minority group in our country and, if we continue our efforts, can become a member of an endangered species that we can gladly allow to become extinct. Ecce signum. □ Howard D. Slobodien, MD

We are sure to be losers when we quarrel with ourselves; it is a civil war and in all such contentions, triumphs are defeats.

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Guest Editorial: 100 Percent Smokefree New Jersey Restaurants

Regina Carlson

The overwhelming majority of New Jerseyans are not smokers and they want and deserve protection. Smokefree policies benefit restaurants. Smokers, too, support controls. Legal action, education, and public demand will make New Jersey restaurants smokefree.

New Jersey has the nation's weakest law on restaurant smoking. It allows restaurants to expose the public to tobacco smoke pollution, requiring only that restaurants post a sign saying, "This restaurant does not offer a nonsmoking area, as permitted by law." Two-thirds of New Jersey restaurants have not complied with the minimum standards of the law—posting signs—and 86 percent of restaurants do not provide nonsmoking areas.[1]

New Jersey restaurants should be smokefree. Tobacco smoke pollution causes immediate physical distress and is implicated in the deaths of as many as 50,000 Americans annually.[2-3] It is the number three cause of preventable death, killing twice as many people as are killed by drunken drivers. The harm done to nonsmokers by tobacco smoke dwarfs that of all other air pollutants combined.

A hazard of this magnitude should be eliminated from restaurants. Restaurants are partners in a contract with society. They are licensed to do business and make a profit but they are required to maintain certain health and safety standards. Just as restaurants are required to heat dishwasher water to a safe temperature and to refrigerate mayonnaise at an appropriate temperature, they also should be required to provide smokefree air in their establishments.

There are numerous other advantages of smokefree restaurants for patrons, for restaurateurs, and for society.

The overwhelming majority of New Jerseyans are nonsmokers (about 75 percent of adults) and they want and deserve protection. Smokers, too, support controls. A 1989 National Cancer Institute survey of smokers and nonsmokers found between 96 and 99 percent of people supported restricting or banning smoking in restaurants.

Clancy's Place, a restaurant in Princeton, asked its patrons if it should become smokefree; 86 percent of the customers voted for a smokefree policy. According to owners, Sean Clancy and Vince Pyleo, customers who smoked clearly understood how offensive smoking is and accepted the subsequent decision for Clancy's to become smokefree. Elsewhere in the nation, restaurants that have gone smokefree report positive customer reaction. For instance, when California Cafe, a chain based in Corte Madera, California, eliminated smoking at its Walnut Creek restaurant, customer comments ran 25 to 1 in favor of the policy.[4]

Smokefree policies benefit restaurants. They attract nonsmokers reluctant to dine out. In 1974, George Callas created nonsmoking areas in his 25 restaurants in New Jersey. He determined that the nonsmoking areas increased business 20 to 25 percent because customers seeking smokefree dining traveled 45 minutes to reach his restaurants, while previously the restaurants had only attracted local patrons, and that senior citizens and parents of young children especially appreciated the nonsmoking areas. Ten years after the nonsmoking sections were first established, Callas said, "I can state categorically and unequivocally it was one of the best business decisions I ever made, and I regret that my fellow restaurantors [sic] have not joined me in laughing all the way to the bank." Today, there are at least 36 entirely smokefree restaurants in New Jersey, and their proprietors are equally convinced that totally smokefree policies make good business sense. Restaurants and restaurant chains elsewhere in the nation that have gone smokefree report an increase in business. The Walnut Creek California Cafe saw a whopping 20 percent increase in business when they went smokefree. A University of California

School of Medicine study comparing restaurants in towns with smokefree ordinances to restaurants in towns not requiring smokefree dining found a small but statistically significant increase in business in the regulated restaurants.[5]

Smokefree restaurants have lower cleaning costs and damage. They experience fewer fires. The National Fire Protection Association reports that 14.2 percent of restaurant fires are caused by smoking. Smokefree restaurants can negotiate lower fire insurance rates. Smokefree restaurants are more attractive to employees and protect employers from liability claims from workers: a California waiter won a $90,000 settlement in 1989 for heart disease judged to have been caused by the smoke pollution where he worked.[6] Patron turnover is faster when customers do not linger over coffee refills and smoking. Reservations and seating are simplified.

Smokefree restaurants can provide a potent public health message. According to the National Restaurant Association's 1991-1992 Food Service Industry Pocket Fact Book, the average American eats out 3.8 meals a week. Encountering smokefree facilities every other day in restaurants reinforces the public perception that nonsmoking is the norm. This especially is important for children; they are confused when they are taught in school about the health hazards of smoking but see society enabling nicotine addiction in public places.

Finally, common sense dictates smokefree restaurants. Secondhand smoke is disagreeable. It spoils the taste of food and pollutes the clothes and hair of customers. Why do restaurants provide pleasant decor and soft music and lighting, and then overlook smoke, which assaults customers with every breath? We do not tolerate loud conversations in restaurants; why tolerate smoke pollution that is more disagreeable and more dangerous?

What about patrons who smoke? Smoking certainly is compulsive. But breathing is involuntary. Smokers can step outside, or postpone a smoke, or become nonsmokers. Nonsmokers cannot hold their breath all through a meal. And smokers cope everyday with smokefree travel, work, public places, and entertainment.

Why aren't New Jersey restaurants smokefree? Customers have not been assertive. Customers just do not return to the restaurant. Also, restaurateurs do not see the nonsmokers who avoid their smoke-filled restaurants. Finally, restaurateurs are the quintessential small business people with strong resistance to controls.

But the most potent force operating against clean indoor air in restaurants in New Jersey is the tobacco industry, which has had a stranglehold on our Legislature and has strong ties with the restaurant industry in New Jersey. Years ago the tobacco industry identified the clean indoor air movement as the single greatest threat to the continued viability of the tobacco industry and they have fought smokefree restaurant laws throughout the nation.[7-8]

What has been done elsewhere? As reported by Drs. Lewit and Meinert and Mr. Botsko in this issue, about half our states and hundreds of cities and counties require restaurants to have nonsmoking areas.[9] Across the river in New York City, an ordinance requiring 70 percent nonsmoking areas in restaurants attracts New Jerseyans. Many citizens, testifying before the New Jersey Commission on Smoking OR Health, reported they go to New York City to dine, sometimes spending hundreds of dollars a year, rather than dine in what many now refer to as "the dirty side of the river."[10]

But smoking and nonsmoking areas in restaurants are something of a fiction, tantamount to chlorinated and nonchlorinated sections of a swimming pool. Increasingly, separate sections are seen as inadequate protection. The State Commission on Smoking OR Health recommends that restaurants be entirely nonsmoking, unless the proprietor wants to construct a physically separated, independently ventilated smoking permitted area.[1]

This is not a pipe dream. In 1985, Aspen, Colorado, became the first American city to require all restaurants be smokefree. In 1988, Telluride, Colorado, and in 1989, Snowmass, Colorado, passed ordinances requiring smokefree restaurants but allowing proprietors to construct separately enclosed, separately ventilated smoking areas. Recently, Flagstaff, Arizona, passed a smokefree restaurant ordinance (effective July 1993). Eighteen California cities and two California counties have passed 100 percent smokefree restaurant ordinances; locales include Sacramento, the state capitol, large, upscale places like Palo Alto and Walnut Creek, and small towns, including poor, rural communities. Bars and cocktail lounges also are included in at least six of the smokefree ordinances.

How can New Jersey restaurants be made smokefree? Three forces—legal action, education, and public demand—will make New Jersey restaurants smokefree. Our new Legislature may be responsive to the health needs of citizens. The well-being of the tobacco industry has seemed to be the priority of our immediate past Legislature. With an Environmental Protection Agency (EPA) Scientific Advisory Board naming tobacco smoke a carcinogen, action from the EPA itself, listing tobacco smoke a class A carcinogen, is expected soon. OSHA is exploring new standards for tobacco smoke in workplaces, but the industry is doing its best to undermine the efforts.

New Jersey Group Against Smoking Pollution (GASP) has

worked for years to educate restaurants about the economic and public health benefits of smokefree dining, providing brochures about the advantages of smokefree restaurants, publishing a directory of smokefree restaurants and restaurants with nonsmoking sections, offering free artwork for restaurants to announce smokefree facilities in their advertising, and reaching out to restaurants through trade conventions and associations. The American Lung Association of New Jersey encourages enlightened restaurants with awards and publicity. In Middlesex County, health department sanitarians, in their regular restaurant inspections, are advocating smokefree facilities and offering restaurants information and free signs from GASP, plus a listing in GASP's restaurant directory.

Public demand is the third factor that asks the question, "When will New Jersey restaurants become smokefree?" With increasing information on the dangers of secondhand smoke and an increasing number of restaurants that have voluntarily become smokefree, I predict a revolution of rising expectations.

For a copy of the GASP brochure listing smokefree restaurants in New Jersey write: New Jersey GASP, Inc., 105 Mountain Avenue, Summit, NJ 07901. ■

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Ms. Carlson is executive director, New Jersey Group Against Smoking Pollution (GASP). Address reprint requests to Ms. Carlson, New Jersey GASP, 105 Mountain Avenue, Summit, NJ 07901.



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Treatment of Hepatic Metastases from Colorectal Origin

Dennis F. Devereux, MD
Michael J. Nissenblatt, MD
John Nosher, MD

Currently, chemotherapy for hepatic metastatic disease is palliative at best. However, successful resection of hepatic metastatic deposits from colorectal origin demonstrates a five-year survival, approaching 60 percent in selected cases.

The American Cancer Society estimates there were approximately 155,000 new cases of colorectal carcinoma diagnosed in 1991. Pestana reported that the liver was the major source of involvement in disseminated colorectal carcinoma in 70 percent of autopsied patients dying of this disease.[1] Several series have revealed that liver metastases play a prominent role in ultimate patient survival.[2-5] However, the prognosis for survival in patients with colorectal carcinoma with demonstrated liver metastases depends on a number of factors including the number of metastatic deposits, the extent of liver replacement by metastases, and the stage of the primary tumor.[5-7,10] Other prognostic indicators have a variable impact in predicting survival; these include the surgical (measured) margins of resection, intrahepatic disease distribution, carcinoembryonic antigen (CEA) level, and number and size of metastatic deposits. It is clear, nonetheless, that the natural history of hepatic metastases from a colorectal primary is associated with only 20 percent five-year survival if a solitary lesion goes unresected and only 3 percent five-year survival if multiple metastases go unresected.[11] However, if these hepatic metastatic deposits are resected, the five-year disease-free survival varies between 25 and 33 percent.[5,18] In fact, surgical resection continues to be the only modality with curative potential for hepatic metastatic disease of colorectal origin. The stage of the primary tumor may be the most significant prognosticator of ultimate relapse. Individuals originally with Dukes B (node negative) disease demonstrate 47 percent five-year survival, whereas those with Dukes C (node positive) disease have only 23 percent five-year survival.[5]

The liver appears to be the initial or the solitary site of failure in less than 20 percent of patients with recurrence following surgical resection of colorectal primary lesions.[7,8,18] Therefore, 30,000 (20 percent) of the 155,000 patients could have potentially resectable hepatic metastases.* It has been estimated, however, that fewer than one-third of these patients actually undergo liver resection for potentially curable disease.[9,18] Is this because an operable potential is not understood? Do physicians feel it is a procedure too morbid to recommend? Do physicians feel patients with hepatic recurrence cannot be cured?

Data from several large centers indicate that mortality from liver resection ranges from 2 to 8 percent; this includes formal lobectomies.[11,19,20] In our experience of 15 formal lobectomies, blood loss averaged 1,200 cc; 2 patients succumbed to pulmonary complications following successful right lobectomies (1 patient with pulmonary embolus and 1 patient with *Staphylococcus* pneumonia). No patient required reoperation or developed hepatobiliary complications, postoperatively. Thirteen other patients were discharged from the hospital after a mean stay of eight days (range 6 to 13 days), attesting to the safety of formal hepatectomies in experienced hands (Table 1).

If surgery is curative in 25 to 35 percent of patients with resectable hepatic disease, however, it must be concluded that between 65 to 75 percent of the remaining patients with hepatic metastases eventually will manifest extrahepatic disease. Of initial recurrences following successful hepatic resection, 33 percent develop in the liver, 15 percent develop within the lung, and 25 per-

*.2 = Percent of patients with solitary hepatic tumor growth out of the 155,000 new colorectal carcinomas diagnosed in 1991 or .2 x 155,000 = 30,000 patients will fail in the liver following surgical resection of the primary lesion.

Table 1. *Protocol for the combined medical-surgical treatment of hepatic metastic disease of colorectal origin.*

"+" Chemotherapy (complete) response	"–" Chemotherapy (incomplete) response
(Histologically confirmed) 9 additional months of successful chemotherapy **Leucovorin + 5-FU**	(Histologically confirmed) 9 additional months of new chemotherapy **Levamisole + 5-FU**

Reassess Status

Complete resection unattainable or extrahepatic intra-abdominal present

Unresectable hepatic disease	Extrahepatic, intra-abdominal, and unresectable hepatic disease	Extrahepatic intra-abdominal disease following successful hepatic treatment
↓	↓	↓
Intra-arterial hepatic chemotherapy via pump	Tenkoff catheter plus hepatic intra-arterial chemotherapy via pump	Tenkoff catheter for intra-abdominal chemotherapy administration

If disease is extra-abdominal, then systemic therapy would be administered.
Objective: Determine disease-free interval and overall survival
MRI: Magnetic resonance imaging
5-FU: 5-fluorouracil

cent develop at other sites including multiple viscera. At late followup, however, the liver remains the only site of metastatic recurrence in only 15 percent of those who were resected, whereas combined recurrences with extrahepatic sites will be noted in 50 to 55 percent of these patients.[6] Since only 33 percent of the patients can be cured with surgery alone and ultimately only 15 percent have been treated for disease that only has hepatotropism, it is evident that systemic metastatic deposits exceed by a factor of nearly 4 to 1 the risk of recurrent liver disease only. Confining therapy of hepatic metastases to the intrahepatic site alone is not likely, therefore, to provide an optimal result of long-term remissions or cure in the majority of patients. Additionally, portal vein infusion of 5-fluorouracil (FU) as an adjuvant to surgical resection of the primary colon tumor has not been shown effective.[13-17] The lack of efficacy of continuous hepatic artery infusion following resection for metastatic disease, in conjunction with a high incidence of biliary toxicity, accounts for the disfavor with which this approach now is being viewed. However, it has been demonstrated that intrahepatic chemotherapy via the hepatic artery does improve survival when used in patients with metastases in the management of unresectable disease.[8,9] It is evident that we need to seek alternative, adjunctive measures in the management of hepatic metastases from colorectal carcinoma.

There now is evidence that the combination of leucovorin and 5-FU provides the greatest response rates for metastatic colorectal carcinoma treated with chemotherapy.[21-23] In addition to partial remission occurring in 25 to 35 percent of patients so treated, an additional 8 to 10 percent of patients achieve complete remission with chemotherapy alone.[23] Partial responses occur with a variety of techniques with which leucovorin (folinic acid) and 5-FU can be administered. Moreover, there now is known to exist an effective measure that can be applied in an adjunctive setting for the management of nonmetastatic but high-risk colorectal carcinoma. The combination of 5-FU and levamisole has been shown in a 401 patient study by the North Central Cancer Treatment Group (NCCTG), and in a study of 1,296 patients by an Intergroup trial to reduce the risk of recurrence by 41 percent and to reduce the death rate by 33 percent, in patients with Dukes C colon carcinoma.[3,4] At 3½ years of followup, survival is 15 percent greater in the treated population than in controls. It is too early to determine whether patients with stage B2 colon cancer will benefit from the administration of levamisole plus 5-FU. However, Moertel has suggested that a select population of those with

stage B2 disease—patients with chromosomal aneuploidy or unfavorable pathologic features (perforation, adhesion, or direct invasion of adjacent organs) that are found to make up to 60 percent of all stage B2 patients—could be predicted to derive a therapeutic benefit from levamisole plus 5-FU alone.[2-4] Such aggressive tumors in fact, may act much like Dukes C patients, who already have benefited from such treatment.

There are three assumptions on which to propose a therapeutic strategy following resection of hepatic metastases: 1. Effective systemic chemotherapy exists for the management of measurable metastatic colorectal carcinoma (folinic acid [leucovorin] plus 5-FU). 2. Persons with high-risk stage B2 and C colon carcinoma have the greatest likelihood of experiencing intrahepatic recurrences even following the successful resection of hepatic metastatic disease. 3. Effective chemotherapy exists for the adjunctive management of high-risk stage B2 and C colon cancer (levamisole plus 5-FU). We, therefore, are seeking and entering patients into the following pilot study.* Patients with resectable hepatic metastases (four or fewer intrahepatic deposits occurring in surgically accessible sites and demonstrating no evident extrahepatic disease) will be treated with three cycles of leucovorin and 5-FU administered according to the North Central Cancer Trial Group Program (low dose leucovorin and daily bolus 5-FU administered on days 1 through 5 and repeated at 29-day intervals). Prior to and at the completion of three cycles of chemotherapy, quantitative measurements of CEA and tumor volumes (estimated by magnetic resonance imaging) will be determined (vide infra). This will allow determination of the effectiveness of this form of chemotherapy in measurable hepatic metastatic deposits. If clinical response does occur, surgical exploration will be undertaken in a maximal effort to resect all intrahepatic deposits, and to assess the intra-abdominal contents. If all disease can be successfully resected, then, upon optimal recovery from surgery, leucovorin and 5-FU will be continued in similar doses for a total of 12 cycles of chemotherapy.

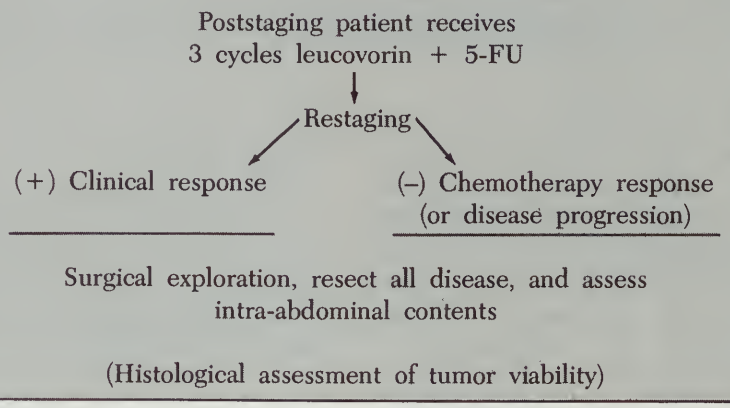
In the event that the clinical restaging following chemotherapy demonstrates either no response or disease progression—but that surgical resection still is feasible based on the confirmed identification of four or fewer liver metastases—then surgical exploration will be undertaken with a maximal effort to resect all intrahepatic lesions. Upon recovery from surgery and a negative response is histologically confirmed, a combination of levamisole plus 5-FU will be administered, as a chemotherapy adjunct analogous to the benefits demonstrated for high-risk stage B2 and C colon carcinoma. Chemotherapy will be continued for an additional nine cycles (totaling 12 months) of treatment (Table 2).

If, at the time of surgical exploration, the patient is found to have extrahepatic metastases or nonresectable intrahepatic disease, i.e. ascites, positive periportal lymph nodes, demonstrable peritoneal deposits, patients will be removed from the "adjunctive" protocol and offered chemotherapy employing either hepatic intra-arterial chemotherapy (with an implantable subcutaneous port for those with liver disease only); intra-abdominal chemotherapy (with an intra-abdominal Tenkoff catheter) for those with unresectable nonhepatic but intra-abdominal disease; or both intrahepatic and intra-abdominal chemotherapy for unresectable hepatic and intra-abdominal spread by implantation of the intra-arterial implantable Port-A-Cath® combined with the intra-abdominal Tenkoff catheter. In the event that the repeat staging prior to surgical exploration demonstrates extra-abdominal disease, i.e. lungs, then exploration will not be undertaken and systemic chemotherapy may be pursued.

This study is a phase II study. Each patient with metastatic colorectal carcinoma receives

Table 2. ***Flow sheet.***

Eligible patients: Those with four or fewer hepatic metastatic deposits (from colorectal rectal primary) resectable by metastastectomy ("wedgeectomy"), formal lobectomy, or trisegmentectomy with at least 1 cm pathologically disease-free margins and no extra hepatic disease demonstrable. All patients are staged radiographically and quantification of intrahepatic disease is achieved by MRI. Pretreatment CEA and CA 19-9 levels also are obtained.



*This protocol is authorized and approved by the Institutional Review Board (IRB) of Robert Wood Johnson University Hospital. Preoperative consent is obtained on all patients as they are aware of our goals following detailed explanation of the protocol.

chemotherapy prior to surgical resection. If the hepatic tumor responded, e.g. by becoming necrotic, presumably, so will the micrometastatic deposits in other sites. Should the hepatic tumor not demonstrate response to the 5-FU and leucovorin (no necrosis), then following surgical resection, the patient will receive 5-FU and levamisole in hopes that the tumor will be responsive to that combination.

The protocol then proposes to answer the following questions: Will hepatic tumor response predict microscopic (extrahepatic) metastatic response? Will hepatic metastatic failure to respond to 5-FU and leucovorin predict (positively or negatively) a response to 5-FU and levamisole? Is there a role for crossover chemotherapy? Is there a role for continued same chemotherapy for a positive, initial response? Can any chemotherapy—continued or crossover—reduce extrahepatic metastatic manifestations following resection?

Each patient, therefore, will serve as his own control. ■

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Dr. Devereux is affiliated with the Department of Surgery, Dr. Nissenblatt is affiliated with the Department of Medical Oncology, and Dr. Nosher is affiliated with the Department of Diagnostic Radiology, UMDNJ-Robert Wood Johnson Medical School, New Brunswick.

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Address reprint requests to Dr. Devereux, UMDNJ-Robert Wood Johnson Medical School, CN 19, New Brunswick, NJ 08903-0019.

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New Jersey's Case for Local Control of the Medicare Review Process

David I. Kingsley, MD
Alexander Rodi, Sr, DO

The government is launching a program called the Health Care Quality Improvement Initiative (HCQII). The government plans to reposition PROs as educational rather than judgmental entities. The PRO of New Jersey, Inc. urges physicians to oppose regionalization of the screening process.

The federal government's Medicare review process is at an unusual crossroads. Some of the news is good and some of the news is bad. New Jersey's health care community needs to take note of both.

THE GOOD NEWS

Peer review organizations (PROs) as educational rather than judgmental entities. The government is launching a major new program called the Health Care Quality Improvement Initiative (HCQII). Through HCQII, the government plans to reposition PROs as educational rather than judgmental entities. Vital to the success of HCQII is enlisting the active participation of physicians and health care providers at the local level in a collaborative effort aimed at improving the mainstream of care.

A key element of HCQII is a software program called the Uniform Clinical Data Set (UCDS), which presently is being piloted by several PROs. UCDS is designed to collect a myriad of patient information that eventually will serve as a catalyst for meaningful discussions regarding patient outcomes and patterns of care among the local health care community.

THE BAD NEWS

Regional instead of local review. The government is proposing to take a crucial part of the federal review process away from the local community—a move that is not likely to encourage local support for HCQII.

Since Congress enacted PROs in 1982, the initial process of screening New Jersey's Medicare patients' medical records has been performed in the Garden State by experienced nurses and medical records professionals. The government intends to take this function away from each state's PRO and to create five Clinical Data Abstraction Centers (CDACs) throughout the country. At these CDACs, the initial screening process would be performed by data entry clerks or other nonmedical personnel. CDACs are expected to be operational in 1993 and will be responsible for screening approximately one million Medicare patients' medical records annually.

CDACs: Cost efficiency or inefficiency? Here is how a CDAC is expected to "fit in" to the federal review process in New Jersey: The PRO requests the medical records selected for review from facilities throughout the state. The PRO mails these records to the designated CDAC. (Each PRO may have more than one designated CDAC.) The CDAC assesses the records for completeness and legibility. The CDAC returns incomplete/illegible records to The PRO. The PRO, in turn, requests the appropriate information from the facility. Upon receipt, The PRO mails the new information to the CDAC. The CDAC gives the records to data entry clerks who will screen the records using the UCDS software program. The computer software program will determine which records require physician review. CDAC mails to The PRO all records flagged for physician review. The PRO performs physician review.

Compare the above steps with the present system: The PRO requests the medical records. Upon receipt, PRO nurses and medical records professionals screen the records using government guidelines and their own professional judgment in determining which cases require physician review. Cases that do not present potential problems are closed. Cases that do present potential problems are referred to a physician reviewer. The PRO performs physician review.

THE BIG QUESTIONS

Why reinvent the wheel? Every PRO in the country has the ex-

perience and the staff to perform the initial screening process. How can the government justify expending scarce federal resources toward creating five new agencies when the means to achieve the end already exist?

How can the government eliminate nursing judgment from the review process? Medicine is both an art and a science. Very few issues arise that can be considered black or white. The Medicare population, most of whom are age 65 and over, have a multiplicity of medical conditions. It takes a trained eye to screen a Medicare patient's medical record to determine the risk factors, complications, and outcomes.

UCDS plus data entry clerks equals a quality review? UCDS is undoubtedly going to be an extraordinary tool for screening medical records. However, it will take significantly more time to refine this tool before it can be implemented on a nationwide basis. The two biggest problem areas currently experienced by the agencies piloting UCDS are: UCDS refers a high volume of cases for physician review that does not need to be referred. This is costly and inefficient. UCDS fails to refer a high volume of cases that should be referred for physician review. This is dangerous.

The PRO of New Jersey, Inc. believes that UCDS, once refined, will be an excellent tool for use by nurses and medical records professionals, not data entry clerks, in performing the initial screening process.

How will the government protect the confidentiality of medical records? Medical records contain confidential patient and physician-specific information. Given that medical records will be mailed back and forth across the country, how will the government guarantee the confidentiality of the highly sensitive information in each record?

Does the government plan to eliminate physician judgment from the federal review process? It is not unreasonable to assume that the ultimate goal of the government is to eliminate physicians as well as nurses from the federal review process. Data entry clerks and computer programs are capable of doing many wonderful things—but exercising medical expertise and professional judgment in assessing the quality of medical care is not among them.

The PRO of New Jersey, Inc. would like the support of the physician community in HCQII. The PRO urges the physician community to oppose regionalization of the screening process because it serves as an ominous harbinger of things to come. ■

Dr. Kingsley is president, The Peer Review Organization (The PRO) of New Jersey, Inc. Dr. Rodi, Sr, is a member of the Board of Trustees of The PRO. Address reprint requests to The PRO of NJ, Inc., Brier Hill Court, Building J, East Brunswick, NJ 08816.

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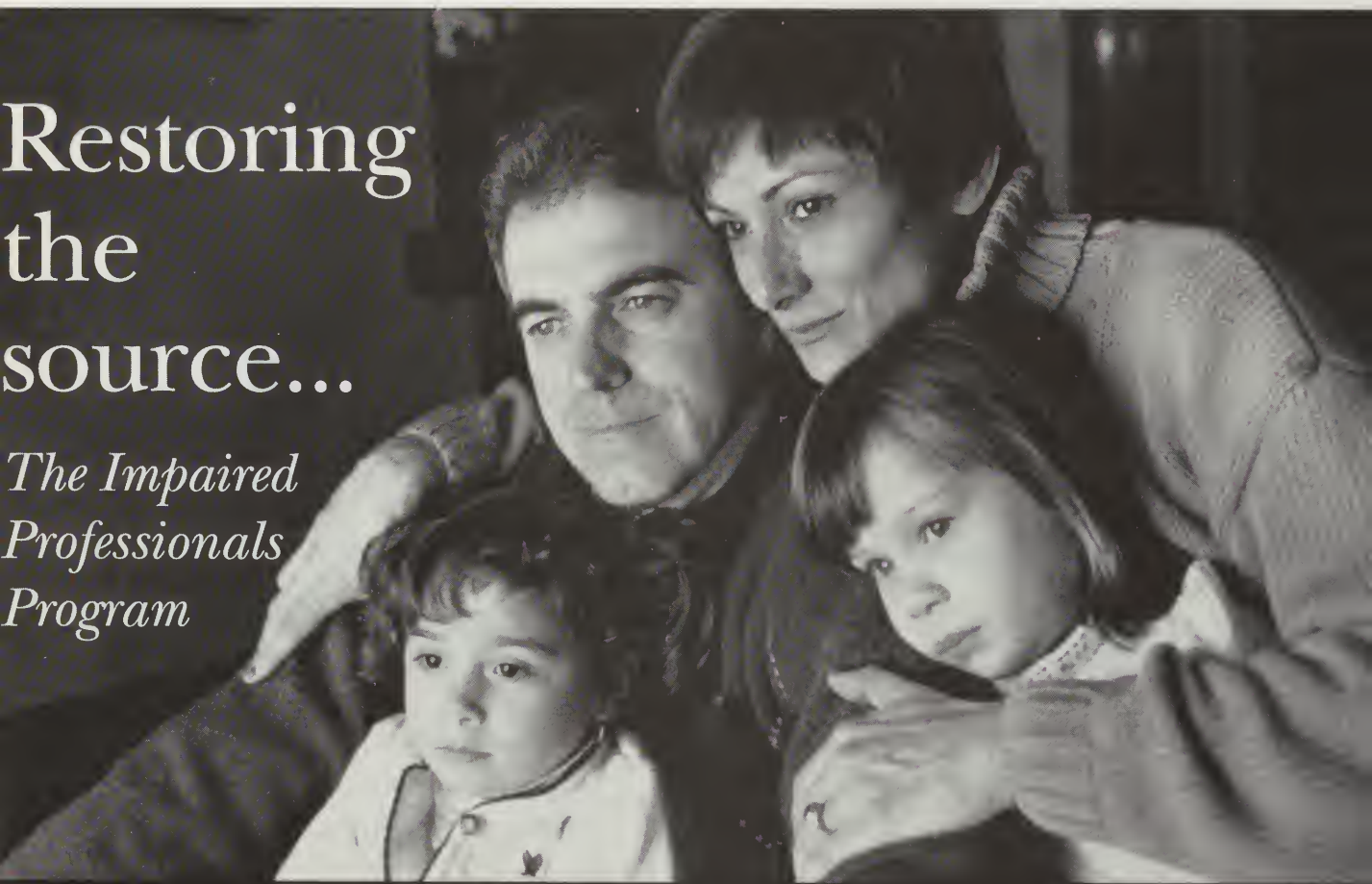
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The Response of Restaurants to New Jersey's Smoking Control Law

Eugene M. Lewit, PhD
Michael Botsko, MSW
Lawrence Meinert, MD, MPH

The authors surveyed a representative sample of New Jersey restaurants to determine what provisions were made for patron smoking, and whether the restaurants were in compliance with the state law intended to restrict smoking in restaurants. The authors report the results of their recent study.

Concomitant with the decline in the prevalence of smoking among adults has been a decline in the social acceptability of smoking in public.[1] Moreover, the mounting evidence that involuntary or passive smoking poses a health hazard to nonsmokers has focused the debate on smoking in public on issues of health and safety and has spawned the growth of public and private restrictions on where and when smoking is permitted.[2,3]

The controversy over restrictions on smoking in restaurants has been particularly intense and some restaurants have responded by voluntarily installing air cleaners, establishing nonsmoking sections, or banning smoking. Anecdotal evidence suggests, however, that most restaurants have not voluntarily made provisions for smoking that are satisfactory to nonsmokers.[4] As a result, the demand for and the enactment of legal restrictions on smoking in restaurants has been increasing. In 1964, only 13 states had any legal restrictions on smoking in public and none of these restrictions addressed smoking in restaurants.[1] By 1987, 43 states had laws restricting smoking to some extent and 23 states had statutes regarding smoking in restaurants.[1] In addition, hundreds of local communities have restricted smoking in restaurants.[1] Although there have been several studies of smoking restrictions in the workplace and other public places, there has been little formal assessment of smoking restrictions in restaurants generally, and of the effects of legal restrictions on smoking in restaurants, specifically.[5]

We report our evaluation of the 1985 New Jersey statute intended "to encourage restaurants to establish nonsmoking areas."[6] The provisions of the law are enumerated in Table 1. The law does not require that restaurants make any special accommodations for nonsmokers. Rather, it requires that restaurants post signs in their entrances to inform patrons of what provisions, if any, have been made for smoking. Moreover, the size and location of any nonsmoking area may be determined solely and completely by the restaurant, which is not responsible for enforcing the nonsmoking provision. Section 6 of the law specifically protects restaurants that have followed the sign provisions of the law from legal actions by patrons for failure to curtail smoking. Also, the New Jersey statute preempts any local ordinances that may regulate smoking in restaurants.

Our evaluation is based on a survey of New Jersey restaurants to determine what provisions restaurants had made to accommodate smokers and nonsmokers and whether restaurants were in compliance with the sign provisions of the New Jersey statute. We also attempted to determine the date when individual restaurants implemented or modified provisions for smoking patrons and included specific questions to evaluate restaurateurs' knowledge of the state law, perceptions of their patrons' demands for provisions for smokers and nonsmokers, and reasons why individual restaurants had adopted smoking policies. Separate tabulations were done for large and small restaurants, to determine if restaurant size was a factor in the creation of special smoking sections.

METHODS

Questionnaire. A four-page questionnaire was developed to determine the provisions made by restaurants for smokers and nonsmokers, restaurant characteristics, and restaurant owner/manager opinions regarding the establishment of special provisions for nonsmokers in restaurants. This questionnaire was pretested with two restaurant

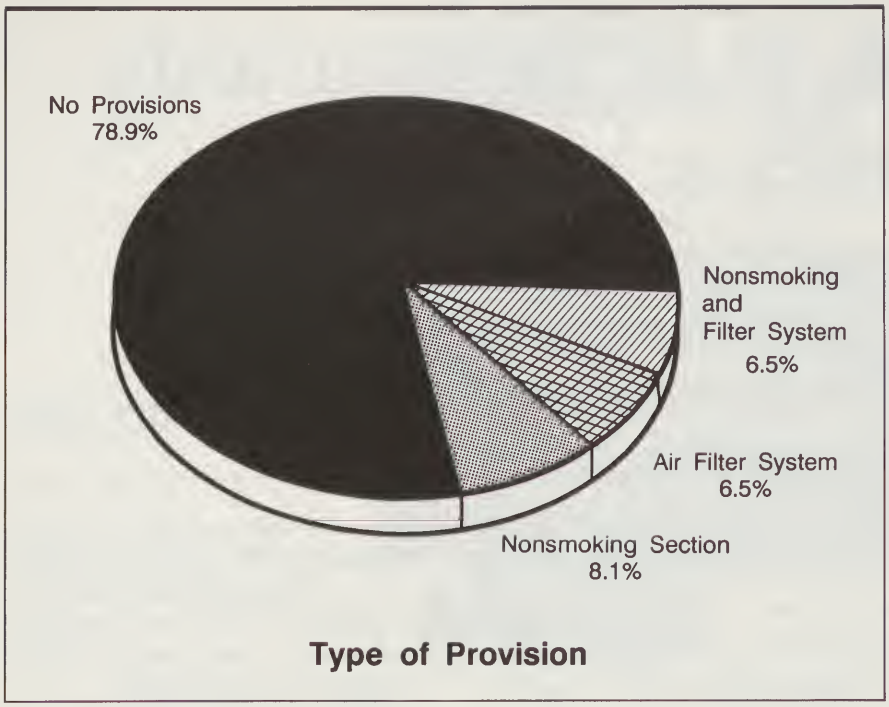


Figure 1. Provisions made regarding smoking in restaurants.

managers. It was noted that the response to the survey might be low because restaurateurs might feel threatened by the survey; it clearly was stated that responses would be kept confidential and would not be used for enforcement.

Sample. Early in 1988, questionnaires were mailed to 201 randomly selected New Jersey restaurants stratified by geographic area. The sample was drawn from all the restaurants listed in the classified telephone directories for every locality in New Jersey and represented 2.3 percent of the 8,753 individual restaurants listed in all the directories. Because an initial and a followup mailing produced a return of only 39 completed questionnaires, the data collection procedure was changed to telephone interview. Opinion questions included in the mail questionnaire were excluded from the telephone interview because our initial experience suggested that busy restaurateurs were reluctant to answer an extended questionnaire over the telephone.

The total number of questionnaires completed by mail and telephone was 124, for an overall response rate of 62 percent. Complete and detailed responses were obtained from 42 restaurants (39 responses by mail and 3 responses by telephone). For the remaining 82 restaurants, only information regarding smoking policies, compliance with the law, and characteristics were obtained. For all respondents, information also was obtained on establishment characteristics including size, average cost of a meal, and type of food.

The sample of 124 respondents appeared representative of New Jersey restaurants. Respondents were drawn from all areas of the state and included restaurants of all sizes and all styles of cuisine. Most restaurants reported $5 to $15 as the average price of a dinner. Approximately one-third of respondents served alcoholic beverages and 75 percent had a separate bar area (excluded from the provisions of the New Jersey statute). The chi-square test was used to evaluate the statistical significance of the differences in rates of compliance observed between large and small restaurants.

RESULTS

Of the 124 restaurants that responded to the survey, 26 restaurants (21 percent) had special provisions for smoking by patrons (Figure 1). Ten restaurants had established nonsmoking seating areas, 8 restaurants had installed air filtration equipment, and 8 restaurants had both air filters and nonsmoking areas. Of the restaurants with nonsmoking sections, 78 percent of the restaurants had posted signs informing patrons of the availability of seating in the nonsmoking section, but only 39 percent of the restaurants seated patrons according to their preference for smoking or nonsmoking areas (Table 2). The mean size of restaurants with nonsmoking sections was 108 seats with the average nonsmoking section comprising 21 percent of total seats. Only 31 percent of restaurants with air filtration devices had posted signs to inform patrons of their use of these devices (Table 2). Restaurants with air cleaning devices tended to be larger than restaurants with nonsmoking sections (149 seats versus 108 seats), although the smallest restaurants in each group were approximately the same size (28 seats versus 25 seats). Restaurants that had made no provisions for patrons' smoking preferences on average were smaller than those that had made provisions (Table 2). Only 23 percents of respondents who did not provide a nonsmoking section had posted signs informing patrons of the absence of a special section as required by the state law. Overall, only 42 of the 124 restaurants (34 percent) responding to the survey reported that they were in compliance with the signing requirements of the New Jersey statute.

One indication of the effect of the New Jersey statute on restaurant behavior is provided by the date when restaurants established special provisions for smoking. The statute was enacted in June 1985 and became effective in December 1985. We conducted our survey two years later. Survey respondents who had made special provisions for smoking in their restaurants were asked the approximate date on

which the special provisions were initiated. Their responses suggest that these actions may have been undertaken in response to the law. Sixty-seven percent of restaurants with air filtration equipment had installed the equipment after the enactment of the law, and 61 percent of restaurants with separate nonsmoking sections had established these sections after the enactment of law (Table 2).

RESTAURANT SIZE/ SMOKING PROVISIONS

Preliminary analysis of survey responses indicated that there appeared to be a relationship between restaurant size and the provisions made for smoking. Many states and localities have enacted statutes that mandate the establishment of nonsmoking sections in larger restaurants (typically restaurants with 50 seats or more).[1] Accordingly, the sample was divided into two groups: small restaurants with fewer than 50 seats (including those that did not report their seating capacity) and large restaurants with more than 50 seats. Each group contained 62 restaurants. Of the small restaurants, 15 percent reported that they had made some special provisions for smoking while 27 percent of the large restaurants had such provisions ($P > .05$) (Figure 2). Only 12 percent of the small restaurants that did not provide nonsmoking sections were in compliance with the legal signing requirement while 33 percent of large restaurants without nonsmoking sections were in compliance with the law ($P < .01$). Large restaurants were almost three times more likely than small restaurants to be in compliance with the sign requirement of the law ($P < .01$).

Table 3 provides additional information about the provisions for patrons' smoking by large and small restaurants. Among the restaurants that had special provisions for smoking, small restaurants were twice as likely as large restaurants to have separate nonsmoking seating areas while large restaurants were twice as likely as small restaurants to use air cleaning systems. Large restaurants also were more likely to have posted signs informing patrons of the availability of nonsmoking sections as required by law and were more likely to seat patrons according to preferences for smoking or nonsmoking sections. There does not appear to have been a substantial difference in the proportion of seats allocated to nonsmoking sections in restaurants of different sizes.

Table 1. ***Provisions of New Jersey Public Law 1985, Chapter 185,*** **An Act Concerning Smoking in Restaurants.**

Feature	Details
Coverage	• Applies to all restaurants. • Does not apply to any bar. • Supersedes any local or other ordinance controlling smoking in restaurants (except for fire regulations).
Provisions	• Restaurants are required to post a sign no smaller than 8″ x 5″ to inform patrons of provisions made for smoking. Signs shall be consistent with restaurant policy and shall read: "This restaurant offers a nonsmoking area" OR "This restaurant does not offer a nonsmoking area, as permitted by law" OR "Approved air-cleaning equipment installed in place of nonsmoking area." • Size and location of nonsmoking area is determined solely by owner/manager. (State or local government may suggest nonmandatory guidelines.)
Enforcement	• State health department responds to written complaint of failure to post appropriate signs. Maximum penalty: $25. • Municipal and/or county health officials may enforce smoking restrictions established by signs. Maximum penalty: $25. • Restaurateur not responsible for enforcing smoking control policies.

DISCUSSION

New Jersey Public Law 1985, Chapter 185 states, "It is in the interest of the public health to encourage restaurants to establish nonsmoking areas." Our survey of a representative sample of New Jersey restaurants suggests that 15 percent of restaurants in the state had established nonsmoking areas almost three years after the enactment of the statute.[6] Moreover, only one-third of restaurants in the state were in compliance with the sign provisions of the law. Even among restaurants that had made some provision for patrons' smoking, only 71 percent had posted the appropriate required signs.

It may be that restaurateurs' lack of familiarity with the law (48 percent of those sampled either were unsure or incorrect regarding provisions of the law) or lack of concern about the penalties for failure to comply with the law were important factors in their lack of compliance. At the time of passage of the New Jersey law, however, it was covered extensively in the media, and voluntary and business organizations including the New Jersey Restaurant Association undertook efforts to inform restaurants of the legal changes.[7] In addition, although it receives no specific funding for any activity associated with the law, the New Jersey State Department of Health (NJDOH) routinely provides information in response to queries about the law. Otherwise, NJDOH's enforcement mechanism is "passive" in that it merely responds to written complaints with a letter of information to the restaurant in question.

Table 2. *Description of restaurants according to provisions made for smoking.*

Features	Restaurants with Nonsmoking Sections* (N = 18)	Restaurants with Air Cleaning Devices* (N = 16)	Restaurants with No Provisions (N = 98)
	Percent of Subsample		
Sign posted informing patrons of provisions for smoking as required by law	78	31	23
Seat patrons by preference for smoking/nonsmoking section	39	–	–
Date Feature Created			
Prior to 1985	11	13	–
During 1985/1986	17	40	–
After 1986	44	27	–
No Answer	28	20	–
Size of Restaurants		Number of Seats	
Mean	108	149	83
Range	25-400	28-500	10-503
Size of Nonsmoking Section			
Mean	23	–	–
Range	6-50	–	–

*Eight restaurants have both air cleaning devices and nonsmoking sections.

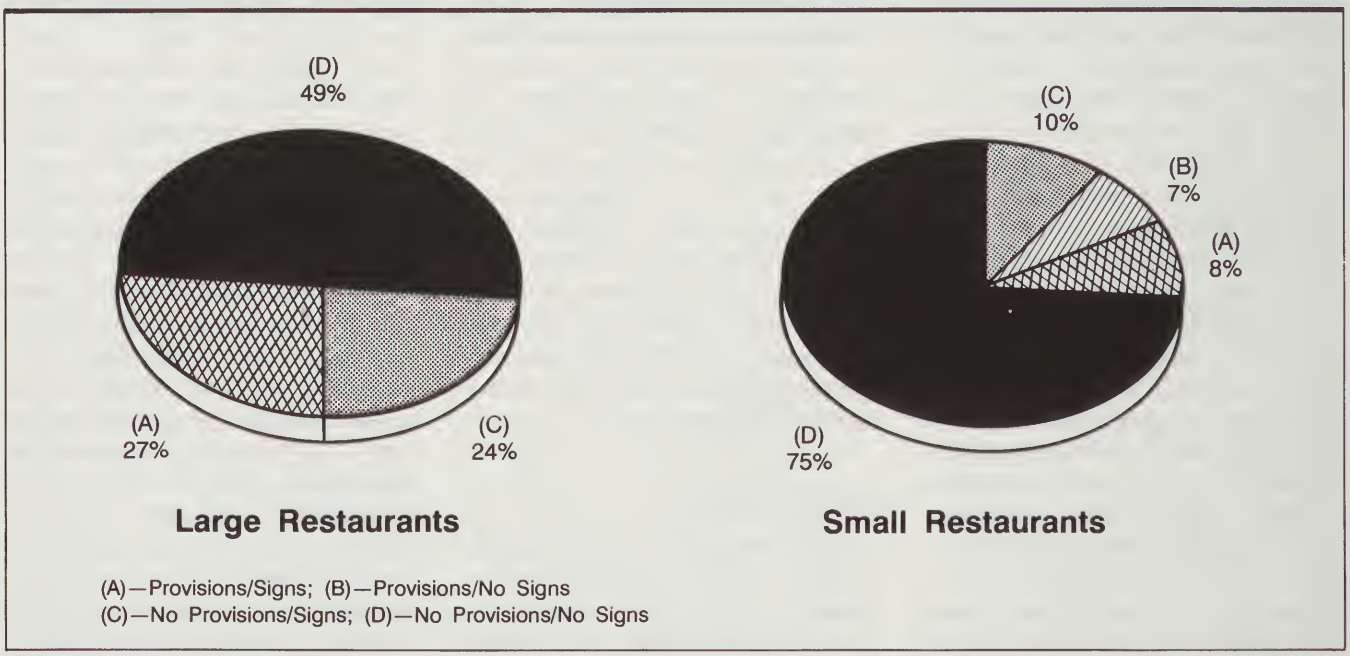


Figure 2. Provisions made for smoking by large and small restaurants.

The experience in New Jersey suggests that even minimal restrictions on smoking in restaurants are not self-enforcing. It appears, however, that compliance with restrictions on smoking in New Jersey's restaurants could be improved at minimal cost. Local health departments in New Jersey already inspect restaurants periodically to assure minimum sanitary standards and occasionally visit restaurants in response to complaints of a violation of the smoking statute.[8] Periodic local inspections could be expanded to include a check for appropriate smoking signs and inspectors could post a sign indicating the provisions made for smoking in restaurants that did not have a sign posted. Then, if on subsequent inspections the sign was not evident, the

Table 3. *Provisions made for smoking according to restaurant size.*

Provisions	Restaurant Size <50 seats (N=9)	Restaurant Size >50 seats (N=17)
	Percentage of Restaurants that Took Indicated Action	
Separate smoking section	100	53
Air cleaning devices	37	76
Among Those with Separate Smoking Sections	**(N=9)**	**(N=9)**
Sign posted informing patrons about separate seating	56	100
Patrons seated according to their preferences for smoking or nonsmoking sections	33	44
Percent of seats in nonsmoking section	29	22
Mean number of seats	32	145

restaurant could be penalized according to the provisions of the existing statute.

Those who authored the New Jersey statute apparently expected restaurant owners to create nonsmoking sections in most restaurants. Although few restaurants have moved in this direction and the minimally restrictive law frequently is breached, the evidence suggests that the law probably did encourage some restaurants to establish nonsmoking areas. The extent to which these changes are attributable to the publicity and public debate that accompanied the passage of the law, the limited educational effort undertaken since the law's enactment, or a growing realization by some restaurateurs that nonsmoking sections are good for business is unclear. However, as the prevalence of smoking continues to decline and evidence of the dangers of exposure to environmental tobacco smoke continues to mount, there is likely to be increased pressure to enact more stringent controls on smoking in restaurants in New Jersey or to at least strengthen the enforcement provisions of existing legislation.[9] In responding to these trends, restaurateurs, even in the absence of a legal requirement, increasingly will find it advantageous to provide nonsmoking areas or perhaps ban smoking altogether. This process may become self-reinforcing as declines in smoking prevalence lead to increases in the prevalence of voluntarily imposed restrictions on smoking that further discourage smoking.

These same factors are likely to lead to renewed efforts to enact more stringent controls on smoking in restaurants in New Jersey or to strengthen the enforcement provisions of the existing law.

CONCLUSION

Policymakers in New Jersey should be able to benefit from reviewing the experiences of other states that have attempted to legally restrict smoking in restaurants. We hope that dissemination of this evaluation will lead to an increased sharing of information and to discussion of the impact of alternative policy options. ■

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Dr. Lewit is director of research and grants for economics, Center for the Future of Children, David and Lucile Packard Foundation. Mr. Botsko was a research analyst, Office of Primary Health Care Education, UMDNJ-New Jersey Medical School; Dr. Meinert was director, Adult Health Services for the New Jersey State Department of Health, Trenton.

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Address reprint requests to Dr. Lewit, Center for the Future of Children, 300 Second Street, Suite 102, Los Altos, CA 94022.

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Infectious Disease Rounds: Pott's Puffy Tumor with Intracranial Complications

Elizabeth Mammen-Prasad, MD
Jeremias L. Murillo, MD
Jules A. Titelbaum, MD

Pott's puffy tumor, a complication of frontal sinusitis, frequently is associated with intracranial infection. Early diagnosis can be obtained by computed tomography. Treatment should include surgical drainage and antibiotic therapy directed against mixed aerobic and anaerobic pathogens.

Our patient was a 13-year-old black male who presented with frontal headache and swelling of the forehead; he denied any history of trauma. The patient was seen in the emergency department and was sent home on oral medication for presumed allergic reaction. He developed fever two days later and was given oral antibiotics. He did not improve and was admitted to the hospital three days later. On physical examination, the patient had a temperature of 102°F. He had a small 3 x 3 cm swelling and induration of the left forehead that was slightly tender. The patient had edema of the left upper eyelid; extraocular movements were intact and he had no proptosis. Visual acuity and fundoscopy were normal. The patient had no neurologic deficits and the rest of the physical examination was normal. His white blood count was 14.8 K/uL with 68% polymorphonuclear leukocytes, 2% band forms, 21% lymphocytes, 8% monocytes, and 1% eosinophils. The erythrocyte sedimentation rate was 110 mm/h. The patient was taken to the operating room the following day and underwent drainage of the frontal subperiosteal abscess. He also had drainage of the sphenoid, ethmoid, and left maxillary sinuses. Forty-eight hours postoperatively, he developed lethargy, disorientation, and expressive aphasia. Computed tomography (CT) scan revealed an epidural collection posterior to the frontal bone, air-fluid level in the frontal sinus, and compressive changes on the left lateral ventricle with a small midline shift. Two days later, the patient was taken back to the operating room for decompressive craniotomy and was found to have an epidural abscess. He was given dexamethasone and Dilantin® for two weeks postoperatively. Slurred speech resolved one week after the craniotomy. Gram stain of the intraoperative sinus drainage showed polymorphonuclear leukocytes, gram-positive cocci, and gram-positive coccobacilli, but the sinus drainage cultures did not grow any organism. The blood cultures were all sterile. The patient received vancomycin, cefotaxime, and metronidazole for six weeks. After completion of antibiotic therapy, the patient was discharged from the hospital with a completely normal neurologic examination.

DISCUSSION

In 1775, Sir Percival Pott described a case of frontal sinus infection causing an indolent puffy, circumscribed swelling of the forehead. Surgical exploration revealed a subperiosteal abscess and osteomyelitis of the frontal bone.[1] This entity now is known as Pott's puffy tumor.

There are several important points to be made in this rather uncommon disease. The unique vascular network of the frontal sinus, consisting of diploic veins that have no valves, allows the unrestricted spread of infection from the sinus mucosa to the cranium and intracranial space. Infection from the frontal sinus may spread anteriorly via diploic veins to the subgaleal space stripping the galea from bone and causing an avascular necrosis of the frontal bone. The end result is a frontal bone osteomyelitis and subperiosteal abscess. The subperiosteal abscess is responsible for producing the circumscribed swelling noted on the frontal area in Pott's puffy tumor. The infection also may spread posteriorly by vascular transmission, via diploic veins to the epidural space or by direct erosion of the posterior wall of the frontal sinus. This produces either an epidural abscess or a subdural empyema. Occasionally, infection from the frontal sinus may spread inferiorly causing orbital cellulitis.[2]

In a review of 11 patients with Pott's puffy tumor, 8 patients developed central nervous system



Figure 1. Axial view, CT scan of the head showing opacification of the left frontal sinus and prefrontal soft tissue swelling with a pocket of air.



Figure 2. Scout view, CT scan of the head showing prefrontal soft tissue swelling with air fluid level.

abscess or empyema and all patients required operative intervention.[3] Therefore, the presence of Pott's puffy tumor should alert the clinician to the high probability of an intracranial lesion. Although frontal sinusitis frequently is a silent infection as illustrated by the case presented, 9 of the 11 patients with Pott's puffy tumor had acute symptoms characterized by headache, rhinorrhea, and fever.[3] Pott's puffy tumor is a disease that is found predominantly in young adolescent males. Occasionally, this infection occurs as a result of a sports injury causing frontal sinusitis.[4]

CT scan is essential in the diagnosis of intracranial complications.[5] The use of CT in the early diagnosis of the intracranial complications has reduced mortality from 40 percent in the pre-CT era to 12 percent with the advent of CT.[6]

Studies on maxillary sinusitis have demonstrated pneumococci and *Haemophilus influenzae* as pathogens in acute sinusitis and anaerobic bacteria in chronic disease. In frontal sinusitis associated with intracranial complications, anaerobes such as *Fusobacterium sp.*, *Bacteroides sp.*, and anaerobic streptococci were the predominant pathogens but viridans streptococci and occasionally staphylococci also were recovered.[7] Anaerobic bacteria thrive very well in this situation because of decreased partial pressure of oxygen in the sinus cavity resulting from loss of ostial patency and decreased nasal breathing.[8] Both mechanisms reduce gas exchange within the sinus cavity. The organisms recovered from patients with Pott's puffy tumor frequently are polymicrobial and include predominantly alpha and beta hemolytic streptococci, anerobic streptococci, *Bacteroides sp.*, and, occasionally, staphylococci and enterococci.[3]

Fortunately, the disease is not common considering the frequency of sinusitis seen in clinical practice. It is estimated that between 0.5 and 5.0 percent of upper respiratory tract infections become complicated by sinusitis.[8] But the signs and symptoms of sinusitis often are nonspecific making the diagnosis difficult. The diagnosis of frontal sinusitis is made even more difficult by the lack of localizing symptoms. In view of the frequent lack of clinical findings, radiologic evaluation becomes an important tool in the diagnosis of sinusitis. Acute sinusitis should be suspected in children with protracted respiratory symptoms beyond 10 days especially with purulent nasal discharge and high fever.[9] The antimicrobial agents that are useful in the treatment of acute sinusitis are similar to those used to treat acute otitis media and include ampicillin, amoxicillin/clavulanate, trimethoprim/sulfamethoxazole, and cefaclor.

SUMMARY

The three important points that should be made in this case are: when the diagnosis of Pott's puffy tumor is made, the clinician should consider the high probability of intracranial infection such as epidural abscess or subdural empyema; because of the silent nature of the initial disease process, radiologic evaluation including CT scan is essential; and because of the high incidence of anaerobes causing this infection, the antibiotic regimen should include activity against this group of organisms. ■

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This column is the first in a series of papers submitted by the Infectious Disease Society of New Jersey. The Infectious Disease Rounds are sponsored by the Academy of Medicine of New Jersey. Dr. Mammen-Prasad is a fellow, Division of Infectious Disease, Dr. Murillo is attending, Division of Infectious Disease, and Dr. Titelbaum is director, Division of Infectious Disease, Newark Beth Israel Medical Center. The paper was submitted and accepted in February 1992.

Address reprint requests to Dr. Murillo, Newark Beth Israel Medical Center, 201 Lyons Avenue, Newark, NJ 07112.

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MSNJ Auxiliary: Responsibility on Water

Nancy M. Propsner

The Medical Society of New Jersey Auxiliary kicked off its Responsibility on Water program. Designed and planned by MSNJA President Marion H. Geib, the program is intended to make children and adults aware of the deadly mix of alcohol and water activities.

There is a great need to focus our youth's attention on "the precarious mix of alcohol and water activities and the relation to injury," claims Surgeon General Antonia C. Novello, MD, MPH. The AMA *White Paper on Adolescent Health* relates that alcohol is the drug abused most often by teenagers. Coast Guard studies indicate that 50 percent of all boating accidents may be alcohol related. An article on adolescent drownings reports 50 percent of drownings among teenagers and young adults are alcohol related. Of the 700 to 800 diving injuries a year, mostly involving adolescent males, 40 to 50 percent are related to alcohol consumption.

Alcoholic beverage advertising portrays drinking as indispensable to youth and beauty, fun and success. Many of these commercials combine drinking, water sports, and water-related activities. The average American youth, by the age of 21, will see more than 100,000 beer commercials.

This year, the Medical Society of New Jersey Auxiliary (MSNJA) inaugurated its Responsibility On Water (ROW) program. MSNJA President Marion H. Geib stated, "As physicians and Auxiliary members, public education is central to our jobs. We must address the social pressures that influence patient behavior. We must teach resistance skills. We must educate everyone about the price we pay when we neglect preventive medicine." More tragically, ROW was prompted by the death of Arlene Liva, corresponding secretary of the Bergen County Medical Society Auxiliary, killed by a drunken boat operator in a boating accident in June 1989.

The kick-off for the ROW campaign was held on May 6, 1992, at the MSNJ Annual Meeting. The plan was designed and introduced by Mrs. Geib, to prevent death and injury of youths mixing alcohol and water sports, e.g. swimming, diving, water skiing, surfing, boating, fishing, and scuba diving, by making children and teenagers aware of the dangers of this deadly mix and changing their attitudes toward alcohol and water sports. The program will include a statewide public awareness campaign with the distribution of promotional materials and various educational efforts.

The ROW campaign will emphasize the dangers of combining alcohol and water sports, along with the negative effects of alcoholic beverage advertising, and water pollution and injury. Each county auxiliary, under the leadership of a county chairman, will promote the ROW program including organizing and sponsoring regional educational programs for students, and implementing a

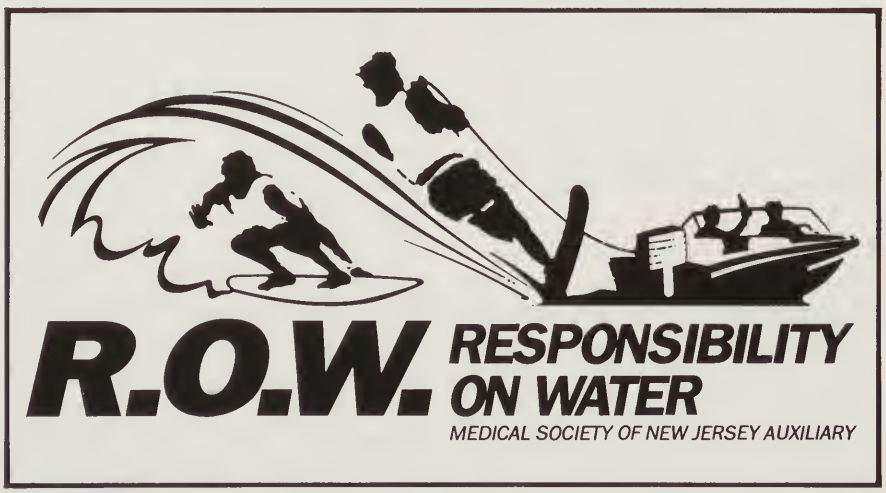


Figure 1. Poster used for ROW campaign.

local public awareness campaign using promotional posters, button pins, stickers, billboards, videotapes, and other public service announcements.

Auxiliary members throughout the state are enthusiastically promoting the program. Gloucester County Medical Society Auxiliary helped to launch the program by raising thousands of dollars prior to the kick-off in Atlantic City. Several coastal county auxiliaries plan to have a plane with a ROW banner fly over the New Jersey shoreline in July. Cape May Auxiliary members will participate in a "Night in Venice," a parade of decorated boats, using the ROW theme. Gloucester County Auxiliary members participated in the Underwood-Memorial Hospital Health Fair in May, where they talked to school children about the dangers of drinking and aquatic sports and distributed button pins and stickers. Auxiliary members from Burlington County are writing educational pamphlets for use at schools, health fairs, marinas, and sailing and swimming programs. Union County Auxiliary members are delivering ROW posters to physicians' offices. The Camden County Medical Society Auxiliary will work in coalition with a local hospital in its alcohol and drug prevention program. ■



Figure 2. Button pin logo.

Ms. Propsner is the editorial assistant of *NEW JERSEY MEDICINE.*

DOCTORS' NOTEBOOK

UMDNJ NOTES

UMDNJ commencement. UMDNJ, New Jersey's university of the health sciences, conferred professional degrees and certificates on over 850 students at its 19th annual commencement ceremony. UMDNJ presented honorary degrees to Dr. Robert Coles of Harvard University, the famed child psychiatrist, and to Dr. Jeanne Sinkford, the country's first woman dean of a dental school.

The University's Medal for Distinguished Humanitarian Leadership went to the illustrious gospel and pop singer Emily "Cissy" Houston. Jean Minskoff Grant, a leading nutritionist and 1977 graduate of UMDNJ-School of Health Related Professions Dietetic Internship Program, received the University's Distinguished Alumna Award.

In addition, Craig S. Nessel became the first person to receive a PhD degree in public health, a new degree never conferred before in New Jersey. The degree was granted by UMDNJ-Robert Wood Johnson Medical School and Rutgers University in a joint program.

Senator Bradley announces TB plan. A plan to curb outbreaks of tuberculosis (TB) in America's inner cities was announced by U.S. Senator Bill Bradley (D-NJ). Senator Bradley's plan involves introducing legislation to establish five model TB Prevention and Control Centers in urban areas at a cost of $25 million—$5 million per center. The senator said that the center locations have not been chosen, but that Newark, with its high incidence of TB, would be at the top of the list for consideration.

Researchers link insulin and growth of nerve cells. Scientists at UMDNJ-Robert Wood Johnson Medical School in Piscataway have discovered that the insulin family of growth factors plays a critical role in the survival and proliferation of nerve cells throughout the body.

The researchers, supported by a grant from the Juvenile Diabetes Foundation, determined that insulin and insulin growth factor (IGF)-I—both hormones—increase the survival of peripheral and brain nerve cells in culture and also encourage the division of these critical cells.

The research may help explain why many diabetics eventually develop peripheral and optic neuropathy, according to Dr. Ira Black, co-principal investigator and professor and chair of the school's Department of Neuroscience and Cell Biology.

Blood-clotting test helps early detection of breast cancer. A blood-clotting test developed at UMDNJ-New Jersey Medical School has been shown to assist in the early diagnosis of breast cancer, heart disease, and other serious disorders.

The test measures the time it takes for blood to clot. Its effectiveness is based on the tendency of many diseases, including heart disease and different cancers, to accelerate the clotting process.

Called a Modified Recalcification Time (MRT) test, the developers of the laboratory procedure await approval of the test by the federal Food and Drug Administration (FDA). The procedure was developed by Dr. Charles Spillert, associate professor of surgery, and Dr. Eric Lazaro, professor of surgery, at the Newark-based medical school.

Study shows fish oil lowers triglyceride levels. Research at UMDNJ has shown that triglyceride levels can be lowered in patients with coronary artery disease and in healthy individuals by giving them daily supplements of omega III fatty acids—fish oil. Triglycerides are believed to play a role in the development of coronary artery disease (CAD).

New drug for ulcerative colitis. Researchers at UMDNJ-Robert Wood Johnson Medical School, New Brunswick, are studying the first of a new class of drugs to treat severe symptoms of ulcerative colitis.

The study focuses on an investigational drug that suppresses the production of leukotrienes, chemicals found in the body that help to sustain bowel inflammation. Dr. Kiron M. Das, chief of the Division of Gastroenterology and Hepatology at the medical school, the only test site in New Jersey, heads the study.

Ulcerative colitis causes chronic inflammation and ulceration of the inner lining of the large intestine, comprising the colon and rectum.

UMDNJ gains environmental award from city of Newark. UMDNJ has received an environmental award from the city of Newark for a solid waste recycling program that has surpassed the state's recycling goal four years ahead of schedule.

UMDNJ was one of four local institutions or agencies to receive a certificate during Newark's recent Earth Day/Arbor Day ceremonies.

Currently, UMDNJ recycles 65 percent of the solid waste produced at the Newark campus and an average of 56 percent of solid waste on all four of its campuses. The effort is saving UMDNJ more than $100,000 a year in disposal costs. □ Stanley S. Bergen, Jr, MD

NEW MEMBERS

The Medical Society of New Jersey would like to welcome the following new members to our professional organization.

Atlantic County

Joseph D. Coffineau, MD
Sunil K. Singh, MD
Sekander A. Ursani, MD

Bergen County

Alan S. Brown, MD
David D. Goldstein, MD
Craig D. Hall, MD
Phillip J. La Stella, MD
Frank M. Moore, MD
Amarjot S. Narula, MD
Ron Noy, MD
Michael J. Pecoraro, MD
Amy T. Rosen, MD
Robert J. Tozzi, MD

Burlington County

Germaine M. Camishion, MD
Charles A. Dennis, MD
Darashana Mahapatro, MD

Camden County

Gary C. Burke, DO
Robert M. Dalsey, MD
Kathleen M. Gekowski, MD
Marc L. Kahn, MD
William M. Leeds, DO
Ronald J. Librizzi, DO
Boris Libster, DO
Loretta L. Mueller, DO
Anthony F. Napoli, Jr, MD
Francis X. O'Brien, MD
Courtland M. Schmidt, Jr, MD
Mario A. Torres, MD

Cape May County

Louis F. Capecci, MD
Michael Dudnick, DO
Ashokkumar J. Patel, MD

Cumberland County

Joseph P. Coladonato, MD
Cynthia L. Janus, MD
Barry E. Shapiro, DO
Maurice S. Sheetz, MD

Essex County

Mahesh D. Chhabria, MD
Thad R. Denehy, MD
Yvonne M. Li, MD
Joseph M. Lombardo, MD

Gloucester County

Pierre N. Coant, MD
Timothy B. McKinney, MD

Hudson County

Warren J. Bleiweiss, MD
Mazhar E. Elamir, MD
Adam A. Paduszynski, MD
Elias M. Pascual, MD
Carol M. Smith, MD
Herman J. Wapelhorst, MD

Mercer County

Susan M. Dashow, DO
Gary G. De Mara, MD
John Ghazi, MD
Gregory A. Kaufmann, MD
Laurel A. Kruse, MD
Robert A. Miller, MD
Raul Munoz, MD
Elaine B. Panitz, MD
Israel L. Sanchez, MD

Middlesex County

Aaron J. Feingold, MD
Howard M. Hendler, MD
Michael A. Marks, MD
Kevin T. Nini, MD
Ricardo S. Viloria, MD
William L. Zinn, MD

Monmouth County

Gregg S. Berkowitz, MD
John DeCerce, MD
Jack E. Ebani, MD
Mark Alan Friedberg, MD
Michael A. Graff, MD
Mark C. Newman, MD
Jyoti R. Pirlamarla, MD
Joseph Sestito, Jr, MD
Robert C. Tomaro, Jr, MD

Morris County

Aaron H. Chevinsky, MD
Ronald V. Ciuffreda, MD
Anthony J. Pisciotta, MD
Joan F. Sorenson, MD

Ocean County

Thomas P. Bonazinga, MD
Robert P. Rabinowitz, DO
Frank J. Sharp, MD
Teresa E. Thomas, MD

Passaic County

Frank C. DeGiacomo, MD
Gary J. Drillings, MD
Anthony A. Losardo, MD
Robert M. Platt, MD
Ali Sedarat, MD

Somerset County

Bonnie L. Camo, MD
James W. Dwyer, MD
Frances Y. Wu, MD
Eric R. Yorke, MD

Union County

Georgina Abich, MD
Kerry S. Bergman, MD
Lorraine J. Brancato, MD
Emanuel Corbo, MD
Nancy L. Freundlich, MD
Kenneth S. Ring, MD
Andrea L. Strauss, MD
Claudia A. Wagner, MD
Ofer A. Werthaim, MD

ARE YOU MOVING?

If so, please send a change of address to *NEW JERSEY MEDICINE*, Medical Society of New Jersey, Two Princess Road, Lawrenceville, NJ 08648, at least six weeks before you move.

Name_____

Old Address_____

City_____ State_____ Zip_____

New Address_____

City_____ State_____ Zip_____

CONTINUING EDUCATION

August

6 **Tumor Board Conference**
13 12:15-1:15 P.M.—Mercer
20 Medical Center, Trenton
27 *(AMNJ)*

7 **Grand Rounds**
21 9-10 A.M.—St. Francis Medical Center, Trenton
(St. Francis Medical Center)

September

11 **Grand Rounds**
18 9-10 A.M.—St. Francis Medical Center, Trenton
(St. Francis Medical Center)

PLACEMENT FILE

The following physicians have written to the executive offices of MSNJ seeking information on opportunities for practice in New Jersey. If you are interested in any further information, please contact the physician directly.

Emergency Medicine

Jayen Shah, MD, P.O. Box 251, Bordentown, NJ 08505. Baroda Medical College 1991. Board certified. Available.

Gastroenterology

Steven Nadler, MD, Robert Wood Johnson University Hospital, MEB 478, GI Division, New Brunswick, NJ 08901. UMDNJ 1987. Board eligible. Board certified (IM). Group, partnership, solo. Available July 1993.

Internal Medicine

Glen W. Berger, MD, Cooper River Plaza, Apt. 809 South, Pennsauken, NJ 08109. UMDNJ 1989. Board eligible. Suburban, private practice group. Available.

Tina M. Josephson, MD, 12043 White Cord Way, Columbia, MD 21044. Hahnemann University 1988. Group or partnership. Available.

Oncology

Barry M. Yafe, MD, 107 Forest St., Providence, RI 02906. New York University 1984. Board certified (ONCOL and IM). Group or partnership. Available September 1992.

Pathology

Sarita Khanijo, MD, 1710 NW Calkins, Roseburg, OR 97470. MGM Medical College (India) 1976. Board certified. Group or partnership. Available.

Pulmonary Medicine

Vinod Khanijo, MD, 1710 NW Calkins, Roseburg, OR 97470. Delhi University (India) 1963. Also, critical care. Board certified. Solo. Available.

Surgery

Mark A. Bartolozzi, MD, Westchester County Medical Center, P.O. Box 17, Valhalla, NY 10595. New York Medical College 1987. Board eligible. Partnership. Available. □

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IN MEMORIAM

URBAN R. BIGLIANI

We regret to announce the death of Urban Ratazzi Bigliani, MD, of North Bergen, on February 12, 1992. Dr. Bigliani was born in 1908, and was awarded a medical degree from Loyola University, Chicago, in 1934. Dr. Bigliani was an orthopedic surgeon. He maintained a practice in North Bergen and was affiliated with St. Francis Hospital, Jersey City, and St. Mary Hospital, Hoboken. Dr. Bigliani was a member of our Hudson County component and of the American Medical Association, and a fellow of the International College of Surgeons. He was a World War II United States Army veteran.

RUSSELL W. DORN, SR

Retired to Las Vegas since 1983, Russell W. Dorn, Sr, MD, passed away on February 10, 1992. Dr. Dorn was born on October 29, 1915, in New York City. In 1940, Dr. Dorn was awarded a master's degree in sociology from Louisiana State University, and in 1950, Dr. Dorn was awarded a medical degree from Columbia University College of Physicians and Surgeons, New York. The following year, he received his New Jersey medical license. Dr. Dorn was a family practitioner. His career included: professor at Vanderbilt University, the University of North Carolina, and the University of Medicine and Dentistry of New Jersey (UMDNJ), Newark; director of Student and Employee Relations at UMDNJ, Newark; private practitioner in Jersey City for 14 years; assistant attending at Jersey City Medical Center; and physician with the New Jersey Athletic Commission for Boxing and Wrestling and with AAU Track and Field. Dr. Dorn was a member of our Hudson County component and of the American Medical Association. During World War II, Dr. Dorn was a United States Navy lieutenant.

SAMUEL J. FORTUNATO

Short Hills resident Samuel Joseph Fortunato, MD, passed away on February 20, 1992. Dr. Fortunato was born on March 1, 1909, in Newark; he attended Jefferson Medical College, Philadelphia, and was awarded a medical degree in 1936. He received his New Jersey medical license the following year. Dr. Fortunato completed an internship at Newark City Hospital. A gynecologist, Dr. Fortunato practiced in Newark, East Orange, and Livingston. Dr. Fortunato's medical career included president and chief of staff at St. James Hospital in the late 1960s; chief of staff at Saint Barnabas Medical Center, Livingston; staff member at Harrison S. Martland Memorial Center, Newark City Hospital, Presbyterian Hospital, and St. James Hospital, all in Newark; member of our Essex County component and of the American Medical Association; and fellow of the International College of Surgeons and of the American College of Obstetricians and Gynecologists. During World War II, Dr. Fortunato was a United States Army captain stationed in Great Britain. Dr. Fortunato resided in Florham Park.

ABRAHAM GARFINKEL

One of the founding physicians of Hamilton Hospital, Abraham Garfinkel, MD, passed away on February 28, 1992, at the age of 88. Dr. Garfinkel was born in New York City on October 29, 1903. He attended the University of Maryland School of Medicine, Baltimore, graduating in 1930. Dr. Garfinkel completed an internship and residency at City Hospital, New York. He received his New Jersey medical license in 1933. Prior to serving in the United States Army Medical Corps during World War II at a military hospital in Trinidad, Dr. Garfinkel practiced in Flemington as a family practitioner. Dr. Garfinkel relocated his medical practice to Trenton after the war; Dr. Garfinkel was chief of staff at the former Trenton General Hospital. Dr. Garfinkel was a member of our Hunterdon and Mercer County components and of the American Medical Association; a fellow of the American Academy of Family Practice; recipient of the Medical Society of New Jersey's Golden Merit Award; and an appointed physician in attendance at the Lindbergh kidnapping trial. During his years of retirement, Dr. Garfinkel resided in Florida and Washington.

DAVID B. MILLER

Former Princeton resident, David Boshart Miller, MD, passed away on January 13, 1992, at the age of 74. Dr. Miller was born in Elmira, New York, on October 21, 1917. Dr. Miller attended the University of Pennsylvania School of Medicine, Philadelphia; he was awarded a medical degree in 1947. Dr. Miller completed a residency at Pfeiffer Surgical Clinic, Philadelphia. He was a general surgeon in Princeton; chief of surgery at The Medical Center at Princeton; professor at UMDNJ; diplomate of the American Board of Surgery; member of the American Medical Association and of our Mercer County component; and fellow of the American College of Surgeons. Dr. Miller retired to Florida in 1979. He served in the United States Army Medical Corps during World War II.

HENRY M. ORNSTEIN

At the untimely age of 53, Henry Morris Ornstein, MD, died on January 23, 1992. Dr. Ornstein was born in Paterson, on January 29, 1938. He was awarded a medical degree from the Faculty of Medicine, University of Geneva, Switzerland, in 1966. Dr. Ornstein completed an internship at Englewood Hospital, and residencies at Presbyterian Medical Center, Denver, and Medical College of Virginia Hospital, Richmond. An obstetrician and gynecologist, Dr. Ornstein practiced in West Palm Beach, Florida, and in Teaneck. Dr. Ornstein was affiliated with Englewood Hospital; he was a member of our Bergen County component and of the Palm Beach County Medical Society; a fellow of the American College of Obstetricians and Gynecologists; and a diplomate of the American Board of Obstetrics and Gynecology. Dr. Ornstein served in the United States Air Force. Dr. Ornstein resided in River Vale and West New York.

WILLIAM A. NYIRI

Ninety-eight-year-old William Anthony Nyiri, MD, of Santa Barbara, California, passed away on February 5, 1992. Dr. Nyiri was born on March 3, 1893, in Vienna. He was awarded a medical degree from the University of Vienna, Austria, in 1916. He served in the Austrian Army during World War I and com-

pleted an internship and residency in Vienna. After immigrating to the United States, Dr. Nyiri, a family practitioner, received his New Jersey medical license in 1927, and practiced in Newark and resided in Livingston. He was affiliated with the former Newark City Hospital; Saint Michael's Hospital, Newark; and Orange Hospital. Dr. Nyiri was a member of our Essex County component, of the American Medical Association, and of the Academy of Medicine of New Jersey; a diplomate of the American Board of Internal Medicine; and a fellow of the American College of Physicians.

ANTHONY L. RIFICI

Asbury Park resident Anthony L. Rifici, MD, died on February 28, 1992. Dr. Rifici was born in Jersey City on December 13, 1915. He was awarded a medical degree from Creighton University School of Medicine, Omaha, Nebraska, in 1943. Dr. Rifici completed a residency at St. Joseph's Hospital, New York, in 1943, and an internship at Monmouth Medical Center, Long Branch, in 1945. Dr. Rifici maintained a family practice in Asbury Park from 1945 to 1980; was employed by Ciba-Geigy, Toms River, from 1980 to 1985; and was school physician for the Asbury Park school system from 1962 to 1988. He was affiliated with Jersey Shore Medical Center, Neptune, since 1945, including director of emergency services, assistant director of the Department of Family Practice, member of the board of governors, and honorary member of the medical staff. Dr. Rifici was past-president, 1965 to 1966, of our Monmouth County component; member of the American Medical Association and of the American Diabetes Association; diplomate of the American Board of Family Practice; and fellow of the American Academy of Family Practice.

THEODORE C. SABARESE

We have been informed of the death of Theodore Charles Sabarese, MD, of Lavallette, on February 22, 1992. Dr. Sabarese was 81 years old. Dr. Sabarese was born on October 10, 1910, in Passaic. He was awarded a medical degree from the University of St. Louis, Missouri, in 1934. The following year, Dr. Sabarese received his New Jersey medical license. Dr. Sabarese was a general surgeon and maintained a private practice in Garfield for 54 years. At Passaic General Hospital, Dr. Sabarese was senior attending, director of surgery, chairman of the policymaking medical board in 1964, and ex-officio member of the board of governors. Dr. Sabarese was a member of our Passaic County component and a fellow of the International College of Surgeons. Dr. Sabarese resided in Garfield, Clifton, and Verona.

VINCENT A. SCUDESE

Orthopedic surgeon, Vincent A. Scudese, MD, died on February 1, 1992; he was born in Newark in 1918. Dr. Scudese was a graduate of Hahnemann Medical College, Philadelphia, in 1944. After serving in the United States Army during World War II, Dr. Scudese was awarded a New Jersey medical license in 1946. He practiced in Newark for 48 years. Dr. Scudese was affiliated with Columbus Hospital, Newark. He specialized in scoliosis and diseases of the spine. During his medical career, Dr. Scudese taught at Seton Hall College of Medicine and at UMDNJ. Dr. Scudese was a diplomate of the American Board of Orthopedic Surgery, and a member of our Essex County component and of the American Medical Association.

MATTHEW J. SHEFT

A recipient of the Medical Society of New Jersey Golden Merit Award, Matthew John Sheft, MD, died on January 14, 1992. Dr. Sheft was born on January 13, 1914, in Passaic. He graduated from Loyola University School of Medicine, Chicago, in 1940, and the same year received his license to practice medicine in New Jersey. He completed an internship at St. Mary's Hospital, Passaic. Dr. Sheft was on staff at St. Mary's Hospital and General Hospital Center at Passaic. Dr. Sheft maintained a general and surgical practice in Passaic from 1943 to 1983, when he retired to Connecticut. Dr. Sheft was a member of our Passaic County component and of the American Medical Association. During World War II, Dr. Sheft was a major in the United States Army Medical Corps.

SVEN E. SVENSON

A 1943 graduate of New York Medical College, New York, Sven Evert Svenson, MD, passed away on February 20, 1992, at the age of 80; he was born in Manchester, Vermont, on July 24, 1911. Dr. Svenson's medical career included: family practitioner in Pompton Plains; staff member at The Hospital Center at Orange and at Saint Joseph's Hospital, Paterson; medical director of research at Hoffmann-LaRoche, Nutley, for 24 years; chairman of the international journal *Advances in Therapy;* and a consultant to New Jersey pharmaceutical companies. Dr. Svenson served in the United States Army Medical Corps in Europe as a battalion aid surgeon; he was awarded the Purple Heart and the Bronze Star. Dr. Svenson was a member of our Essex County component, the Academy of Medicine of New Jersey, the American Medical Writers Association, and the American Society for Pharmacology and Therapeutics. Dr. Svenson resided in Montclair, North Caldwell, and Jamesburg.

WOLODYMYR ZANKIW

Wolodymyr Zankiw, MD, died on February 4, 1992. Dr. Zankiw was 73 years old. He was born in Baligrod, Ukraine, on November 11, 1918. Dr. Zankiw attended the University of Innsbruck, Austria, and was awarded a medical degree in 1951. He received his New Jersey medical license in 1959. Dr. Zankiw was a radiologist who practiced in Jersey City. He was affiliated with Palisades General Hospital, North Bergen. He was a member of our Hudson County component and of the American Medical Association, and a diplomate of the American Board of Radiology. Dr. Zankiw served in the United States Medical Corps from 1953 to 1955.

EDITORIAL CRITERIA

CONTENT

NEW JERSEY MEDICINE is the official organ of the Medical Society of New Jersey. The goals are educational and informational. All material published is copyrighted by the Medical Society of New Jersey.

The educational contents of each issue appear as scientific articles, based on research, original concepts relative to epidemiology of disease, and treatment methodology; case reports; review articles; clinical notes; state of the art reports; and special articles, that include evaluations, policy and position papers, and reviews of nonscientific subjects. Other topics include professional liability commentary; critical narration; medical history; pediatric briefs; nutrition update; and opinions. Editorials are prepared by the editor and by guest contributors on timely and relevant subjects. The Doctors' Notebook section contains organizational and administrative items from the Medical Society of New Jersey and from the community. Letters to the editor and book reviews are welcome and will be published as space permits.

The principal aim in the preparation of a contribution should be relevance to diagnosis and treatment and to the education of patients and professionals. Preference will be given to authors from New Jersey and to out-of-state lecturers submitting a suitable manuscript based on a presentation made to an audience in New Jersey.

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"In consideration of *NEW JERSEY MEDICINE* taking action in reviewing and editing my submission, the author(s) undersigned hereby transfers, assigns, or otherwise conveys all copyright ownership to the Medical Society of New Jersey, in the event that such work is published in *NEW JERSEY MEDICINE.*"

SPECIFICATIONS

Submit two manuscripts that must be typewritten and double spaced on 8½" by 11" paper. Statistical methods used in articles should be identified.

The title page should include the full name, degrees, and affiliations of all authors, and the name and address of the author to whom reprint requests and correspondence should be sent.

The author should submit a 30-word abstract to be used at the beginning of the article.

Tables must be typewritten and double spaced on separate 8½" by 11" sheets, with a title and number. Symbols for units should be confined to column headings, and abbreviations should be kept to a minimum.

Illustrations should be professional quality, black-and-white glossy prints. The name of the author, figure number, and the top of the figure should be noted on a label attached to the back of each illustration. When photographs of patients are used, the subjects should not be identifiable or publication permission, signed by the subject or responsible person, must be included with the photograph. Material taken from other publications must give credit to the source.

Generic names should be used with proprietary names indicated parenthetically or as a footnote with the first use of the generic name. Proprietary names of devices should be indicated by the registration symbol—®.

The summary of the article should not exceed 250 words; it should contain essential facts.

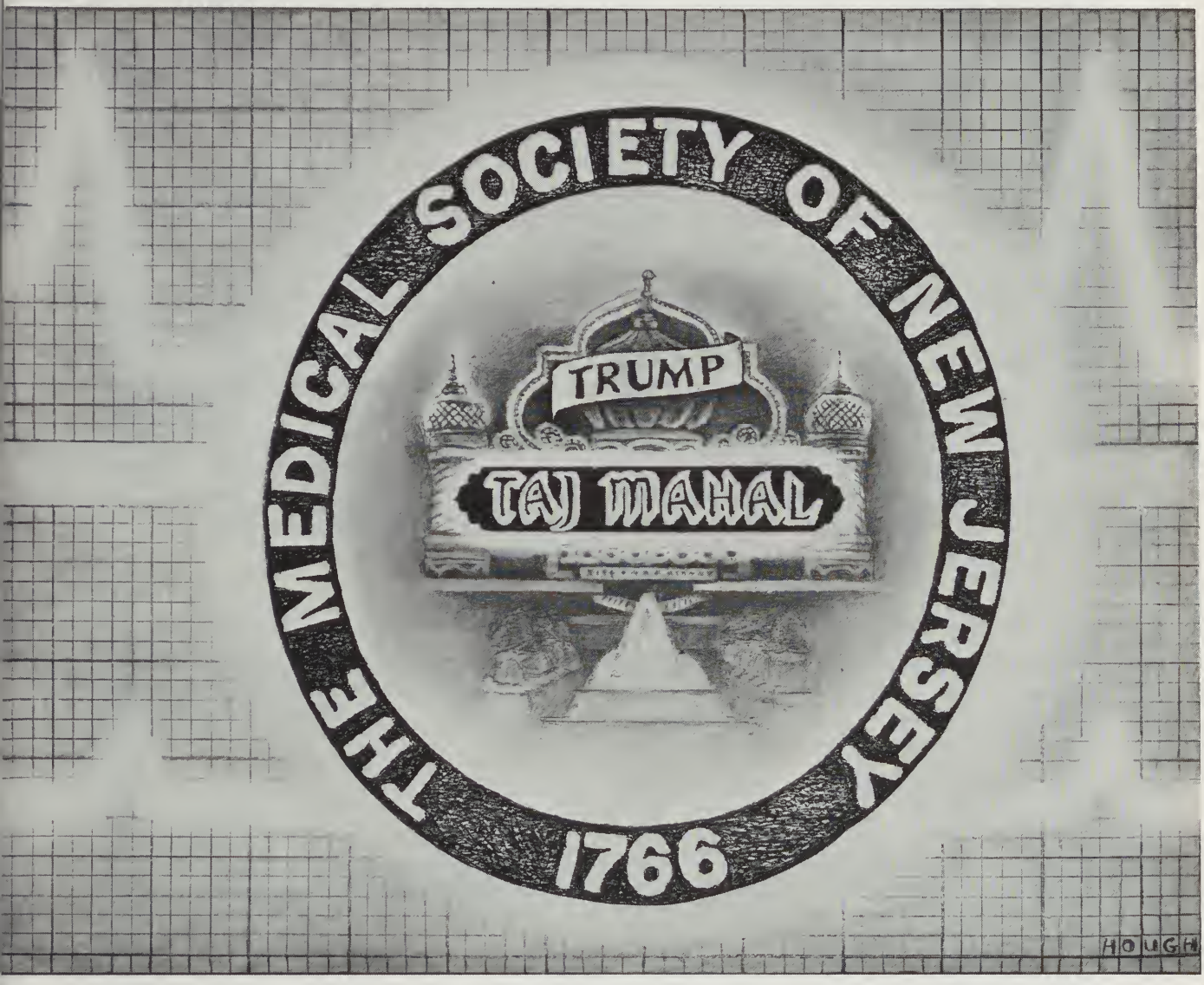
References should not exceed 35 citations except in review articles, and should be cited consecutively by numbers in parentheses at the end of the sentence. The style of *NEW JERSEY MEDICINE* is that of *Index Medicus:*

1. Goldwyn RM: Subcutaneous mastectomy. *NJ MED* 74:1050-1052, 1977.

PUBLICATION POLICY

Receipt of each manuscript will be acknowledged; the paper will be referred to the Editorial Board. Final decision is reserved for the editor. No direct contact between the reviewers and the authors will be permitted.

All communications should be sent to *NEW JERSEY MEDICINE,* MSNJ, 2 Princess Road, Lawrenceville, NJ 08648. □



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Offices Filled by Election Tr59

1991 Transactions

The House of Delegates approved the Transactions of the 1991 Annual Meeting and the Special Session, as published in *NEW JERSEY MEDICINE.*

Action To Limit Debate

The House of Delegates agreed, upon motion duly made and seconded, that no one may speak more than once on any given subject except in rebuttal or by express permission of the House, and that floor time in each instance shall be limited to four minutes unless exception is made by the House.

Reports and Resolutions

Reports and resolutions and the actions, thereon, are included under the Reference Committee to which they were assigned. The House takes action only on the resolved sections of a resolution.

Presidential Appointments

Speaker: **Karl T. Franzoni, MD, Mercer**
Vice-Speaker: **Walter J. Kahn, MD, Monmouth**
Chief Sergeant-at-Arms: **Charles M. Moss, MD, Bergen**
Sergeants-at-Arms: **Louis G. Fares, II, MD, Mercer; Judith C. Gellrick, MD, Bergen; John C. Riggs, MD, Camden**
Chief Teller: **George T. Hare, MD, Camden**
Chairman of Reference Committee on Credentials: **Carl Restivo, Jr, MD, Hudson**

President/Chairman of the Board of Trustees

Joseph A. Riggs, MD

Reference Committee on Constitution and Bylaws/"A"

The Medical Society of New Jersey (MSNJ), the oldest medical society in the United States, elected the Reverend Robert McKean, MD, clergyman and physician, as the first president in July 1766. Much has changed since then. As my year as MSNJ president comes to an end, it is time for me to render an accounting of my term in office to the members of MSNJ.

I have had the opportunity to see MSNJ from the bottom up and the top down. I know how it looks both ways, and I like what I see. Despite the perils that exist, we have remained true to our highest ideals. We have continued to pursue vigorously all those activities that are in the best interest of our patients and our profession. We have fought, and without apology, to not relinquish control of our profession to any group, whether it be hospitals, government, entrepreneurs, or others.

With keen awareness and close observation, I have observed the performance of MSNJ, and hereby report to you with confidence, hope, and great joy that we are moving in the right direction.

Four unexpected issues. In my inaugural address, I outlined many plans that I had hoped to accomplish. However, four serious, unexpected, and almost overwhelming issues occurred in succession during the year that interfered with the good intentions anticipated.

1. AIDS. This House well remembers how much we debated over many years, the sensitive AIDS issues that have arisen from this awful disease. However, on April 30, 1991, this House took bold action by passing resolutions calling for universal widespread testing of all patients being admitted to hospitals, and periodic testing of all health care workers, including physicians. MSNJ was the first society in the United States to make such strong declarations, and the country was waiting for someone to take the lead. This was followed by immediate major nationwide newspaper and television interviews and reporting.

The excellent work done by MSNJ's Task Force on AIDS, in cooperation with members of the New Jersey State Department of Health (NJDOH), had finally come to fruition. This issue became a perfect example of how medicine and government can work together for the betterment of all. The benefits of this cooperative effort have begun to show. The number of new cases of AIDS in New Jersey per year has decreased from 2,305 in 1989 to 1,697 in 1991. Many of our recommendations were used later as a basis for similar recommendations by the AMA, the Centers for Disease Control, and other state medical societies. I was proud to be your president during those hectic days.

2. Resource-Based Relative Value Scale (RBRVS). A few years ago, Congress passed laws that would allow for the RBRVS method of reimbursement to take effect in 1992, in a budget-neutral fashion. However, in June 1991, the Health Care Financing Administration (HCFA) published a payment schedule that called for an immediate cut in physician reimbursement, causing physicians to be confused, frustrated, and angry. A letter immediately was sent to all the membership, petitioning them to contact the administration, HCFA, and all our legislators to oppose this unfair and inappropriate reduction. We want to thank all members of

MSNJ who took time out from their busy schedules to respond, allowing New Jersey to be in the forefront of the battle against HCFA. The result was a restitution of 95 percent of the proposed cuts.

Although government consistently and unapologetically ignores the realities of growing demands, increasing numbers, improved technology, and elevating expenses, we must, nevertheless, attempt to live harmoniously with this new system, while still battling for changes in the system that will more fully guarantee access to care for all New Jersey citizens.

3. New CPT Codes. The battle of RBRVS was just finished when it was announced that a new CPT coding system would be coming into effect. MSNJ, in cooperation with Pennsylvania Blue Shield officials, carried out numerous symposiums, giving out information about the use of the new codes. The sessions were fully attended and the membership expressed deep appreciation. At the same time, in cooperation with AMA officials, the New Jersey delegation helped to delay implementation of the new CPT codes until March 1992, when members were more able to understand the intricacies of the new system.

4. State Health Plan. In 1990, the Health Care Cost Reduction Act (Codey bill) was passed, which had a tremendous impact on the way medicine would be practiced in New Jersey. One portion of the bill mandated that a State Health Plan (SHP) be developed by 1992, which would outline health care issues for the 1990s. In late 1991, the administration, along with NJDOH, drafted, in a closed process, Phase I of SHP. Earlier, MSNJ officers and staff had complained to the administration about the lack of physician input in health care matters, but this plea was virtually ignored. Thus, the executive committee and staff of MSNJ, after much deliberation and discussion with many of the membership, developed "Alternatives to Centralized State Planning," a document containing 42 pages of recommendations to change the original draft. This document was sent to all county societies, specialty societies, and New Jersey legislators. Indeed, SHP was rewritten, with some changes made, and then later adopted by the Health Care Administration Board (HCAB) through a formal process. Throughout the entire process, the medical community was systematically underrepresented. Interestingly, quality of care was not mentioned in the planning goals of Phase I, and the focus seemed to be on cost containment and access to alternative providers.

At the time of this writing (March 1992), Phase II of SHP is being written, however, with some MSNJ input. The final outcome of SHP has not yet been determined, but let it be known that MSNJ always will fight to ensure the health, safety, and welfare of our patients and our profession.

Anticipated Activities. The four issues mentioned occupied the majority of my time as your president this past year. However, I do want to report on many expected activities that brought about a sense of accomplishment.

1. Legislative/Regulatory Activity. This was a very unusual year legislatively. It was divided into three parts. The first part of the year was Democratic controlled; the next portion was a lame duck session; and the third part will address matters before a Republican-controlled legislature.

Throughout the year, MSNJ tried to move from a less confrontational position to a position of accommodation with the State Board of Medical Examiners, legislators, regulators, elders, Auxiliary, women's groups, and international medical graduates.

We enjoyed more political contributions than ever before in history, and have tried to raise MSNJ to a level of legislative sophistication. We now possess the resources, talent, and enthusiasm to become a major political force, under the excellent guidance of our lobbyist, Mr. Clark Martin.

A. Mandatory Medicare Assignment. We had waged a yearlong battle against the bill to overcome Governor Florio's frequent calls for its passage. The bill, released by the Assembly Senior Citizens Committee last February, would have prohibited physicians from charging more than the Medicare "reasonable" rates when treating a senior whose annual income is less than $34,125, if single or $41,875, if married.

At 8:00 P.M. on January 13, 1992, the Assembly adjourned without calling the bill to a vote. But even if it had passed in the lower house, we saw its prospects in the Senate as minimal.

B. Nurses and Physician Assistants. In particular, the passage of the physician assistants (PA) bill was a victory for the University of Medicine and Dentistry of New Jersey. Its PA training program has existed for 17 years, and yet it had been unable to win statutory authority to permit its PA graduates to function in New Jersey.

The original nurse practitioner legislation was unartfully drafted. It equated the nurse's diagnostic abilities and prescription privileges with those of a physician. But through protracted negotiations with MSNJ, a more palatable measure was written in which the nurse practitioner would work under the direction of a physician, with protocols to be adopted by the State Board of Medical Examiners and the State Board of Nursing.

Most legislators felt that the PA issue had been substantively decided last year when the State Board of Medical Examiners—moving more quickly than the Legislature—adopted regulations to permit PAs to work in New Jersey under a "pilot program."

In addition, the PA legislation requires physicians to supervise PAs. No participating doctors equals no PAs. In political parlance, this is called "permissive" legislation, and that is how legislators viewed the matter.

If physicians do not want PAs working for them, they do not have to hire PAs. If the medical staff of a hospital does not want PAs, it will not amend its bylaws to allow PAs to work in the hospital. Doctors still are in charge, and it is up to them to ensure that PAs practice properly.

In the end, the PA bill, which had passed the Senate in January by the minimum 21 votes necessary, passed in the Assembly unanimously—an outcome that had been set in motion from the time the New Jersey State Nurses Association dropped out of the battle and the State Board of Medical Examiners voted to permit PAs to function in a limited number of facilities.

C. Optometric Use of Drugs. None of the above applies to the controversial optometric drug bill. Passage of the measure capped a ten-year battle between optometrists and ophthalmologists over the legislation.

The ophthalmologists, with the help of MSNJ, were ahead in the battle for most of last year. Then, they mysteriously began losing support among key legislators. The mystery was cleared up in December 1991 when Common Cause unveiled a letter sent by the Optometric Association to its members extolling them to throw money at the lame duck Legislature.

"It's time for each of us to realize that we're not going to get this bill 'on the cheap.' No one is going to 'give us' the bill just because it's in the public interest. Unless each of us digs deep into our wallet, so deep that it hurts, we're not going to get the bill. Hard work and tons of bucks will get us this bill this year," said the letter.

The implications of this episode should be clear to other specialties. If optometrists can move laws that enable them to practice medicine without a medical degree, other groups of nonphysicians cannot be far behind.

D. A Longer View. While the final hours of the 204th Legislature may be fresher in our minds, there are other reasons to recall activities particularly significant to the medical community. Foremost is the quick passage in 1990 of the Fair Automobile Insurance Reform Act that established a schedule of fees for medical treatment under PIP with no balance billing. This law was the precursor of the mandatory Medicare battle and made it symbolic of the greater issue before us: total state government control of physician income. The 204th Legislature is gone, but this issue is gaining momentum as the cost of health care has risen to the very top of the heap of problems confronting legislators on both the state and national levels.

The Legislature also passed the Comprehensive Health Care Cost Containment Act of 1991, which brought many physicians under the certificate of need program for purchasing equipment with a price tag in excess of $1 million, placed limits on physician dispensing, and prohibited the referral of patients to new physician-owned facilities located outside of their places of practice.

2. Litigation. Although the Board of Trustees often does not like to resort to this method of solving issues, we sometimes have to litigate when it is necessary to protect the rights of our patients and our profession.

A. Biennial Licensing. The biennial licensing form used by the State Board of Medical Examiners had a chilling and depressing impact upon the profession. MSNJ achieved injunctive relief against the most oppressive questions on an emergent basis and the renewal process was conducted with a revised form.

Subsequent to that, full argument was held in the Appellate Division and the court modified the previous order. MSNJ has petitioned for certification. All briefs have been submitted and we are awaiting notification from the Supreme Court.

B. No-Fault. We have filed suit against the state regarding the no-fault fee schedule and the licensing tax of $100.

The Tax Court ruled against us on the licensing fee and the decision was appealed. That issue, along with our challenge to the fee schedule and the ban on balance billing, have been consolidated in the Appellate Division and we await the assignment of a hearing date.

C. Physician Assistants. Our suit against the illegal regulation of the State Board of Medical Examiners regulation has reached an amicable solution.

The Legislature resolved the question by enacting its version of a licensing act. The State Board of Medical Examiners then agreed with us that the regulation they adopted was in conflict and must be withdrawn. Our attorneys are in the process of working out the final details that will allow the two or three programs they have authorized to continue until the legislative act is implemented in July. No new programs are to be initiated.

D. Chiropractic Suit for Hospital Staff Privileges and Admission. A chiropractor filed suit against Dover General Hospital, demanding admission to the hospital medical staff. MSNJ and the New Jersey Hospital Association have entered the case on an amicus basis. In the preliminary hearing, the court ruled against the chiropractor. MSNJ has maintained that chiropractors do not practice medicine, and therefore have no right to admit patients to acute care facilities or to be members of a "medical staff."

3. Public Relations. The Council on Public Relations, under the chairmanship of Andrew Coronato, MD, has begun to reestablish the private sector as the

cornerstone of our medical system. Many advertisements in newspapers and magazines were issued. Billboards sent messages to our citizens throughout the state.

Several years ago, there was an impassioned plea by the House for funds for public relations, and a special assessment was imposed. This was eventually received with less enthusiasm and even some hostility by some of the membership. However, there is no doubt that more funds will be needed in the future years for public relations. Perhaps this could be accomplished under the present dues structure.

We need to spend more time and money to educate and to inform the public. We need to tell them the truth about national health insurance and the State Health Plan. There are many flagrant violations of the rights and freedom of physicians and their patients. We need to approach the public with common sense and intelligent action. Finally, we must always consider what people want, not what government, or business, or physicians want.

4. Medical Inter-Insurance Exchange (MIIX). It gives me great pleasure to make a few comments about the New Jersey State Medical Underwriters, Inc. (NJSMU), which operates the Medical Inter-Insurance Exchange.

The Society organized the Exchange and chose to operate it through NJSMU. We charted this course of an inextricably intertwined relationship in late 1976 and we vigilantly have maintained it.

During 1990, we suffered a tragic loss in the death of Mr. Peter Sweetland, a fine gentleman and friend who had served as president of NJSMU since 1977. In June 1990, we began a reorganization that was highlighted by employing Mr. Daniel Goldberg as president of NJSMU. His energy, knowledge, judgment, instincts, and leadership have reconfigured our company and your insurer. We are well positioned to meet our obligations to our insureds and the challenges of the medical/legal environment.

We are committed to your protection and to your service.

5. Membership. The inability of MSNJ to significantly increase membership has been a tremendous concern. As the House knows, this has been the number one priority of almost every president in the past decade. If we are going to be successful in our campaign to ensure the delivery of quality care to every person in New Jersey, all physicians must get personally involved, because political power is based at the grassroots level.

However, I feel that we will notice an increase in membership in 1992; the mechanism is in place. This year we have witnessed the reorganization, commitment, and energy of three committees—Ad Hoc Committee on Membership; Committee on Women in Medicine; and Committee on International Medical Graduates—all working together to increase membership. A list of nonmember physicians was obtained from the AMA. Via the county medical societies, the Committee on Women in Medicine encouraged all member women physicians to contact, one-on-one, all those women physicians who do not belong. The same procedure was carried out by the Committee on International Medical Graduates. It is too early in 1992 to realize the results of such action, but I sincerely believe that, in the long run, this mechanism will produce a sizeable increase in membership. As servant leaders we must seize the moment to get involved as only physicians can. Only then will our future be filled with promise, hope, and brightness.

6. Health Care Reform. If states are the battleground for health care reform, New Jersey is at the front of the line. In 1978, the Garden State made headlines by deciding to pay hospitals via DRGs. This has proved to be less than successful, as 40 percent of acute care hospitals operated in the red in 1991.

This was followed by the Uncompensated Care Trust Fund, which provided that insured paying patients will pay for uninsured nonpaying patients, causing increases of premiums for those insured by 19 percent last year. This issue will surface again before June 1992.

The debate about New Jersey's health care reforms moved further backward with the new administration's "CARE" proposals of 1991 that were "pushed through" the Legislature without physician and MSNJ input.

In 1992, we are addressing another administration fiasco called the State Health Plan. Once again, this method of health care reform is being "blitzed" through the state without proper and adequate physician, hospital, and public input. The present system of private health care slowly is being overshadowed by a regulatory system that, at best, is an overly complex, overly regulated system.

It is my sincere regret that I was not able to establish a better working relationship with the Florio administration as I had hoped. Only by having government and medicine working together will any meaningful health care reform be able to be carried out.

7. Auxiliary. This year has witnessed an excellent working relationship with the MSNJ Auxiliary. "Working together we do it better" has been our motto. We have held many meetings together, have jointly cosponsored symposia on "Medicine and the Media" and "Choice, Not Chances." We have petitioned legislators, and will travel together on a legislative trip to Washington, DC. The Auxiliary is an active and invaluable source of energy, and it is a pleasure to work closely together with them.

8. County Medical Societies. A society is only as strong as its

component societies. This year we established the Council of County Society Presidents. The Council met every two months in Lawrenceville, and county society presidents and executives were kept up to date on state happenings, and they, in turn, reported back to their membership. It also allowed them an opportunity to express their ideas, have their questions answered, and to get better acquainted. Their accomplishments provide the platform on which we build at the state level.

It is not necessary, or even healthy, that individual county society leaders and state leaders agree on every issue; via the Council of County Society Presidents we could develop a consensus and then act in a manner that will be beneficial to all concerned.

Also, our schedule to date has permitted us to visit and enjoy the friendship and collegiality of 18 of the 21 county medical society dinner meetings. We have asked for counsel, support, and advice from members of each county, and they have responded well. How generous they have been to take us into their meetings, their dinners, and their hearts; we are most grateful.

9. Open Forum. At the meetings of the Board of Trustees in October and March, we held an open forum for anyone to present an opinion, viewpoint, or idea. The Society leadership always has been open and available to hear from any physician, member or nonmember, who had anything to say.

Regrets. Considering the vast amount of time and activity created by the issues stated above, I did not accomplish some of the things I wanted to do. I wish I had been able to address AARP, the Chamber of Commerce, and business and labor leaders, and to approach insurance issues. I hoped to work closer with the Hospital Medical Staff Section, and report activities to each hospital staff. At times, I hoped there would be a second year as president to carry out all these projects and ideas. Nevertheless, the year was busy, exciting, and thoroughly enjoyable.

Conclusion. We have always put the patient's welfare first; we have showed the need to maintain professionalism; we have kept the membership informed; and the overworked staff has kept me organized and in order as we met the challenges. In return, I have tried to serve you well, faithfully, and loyally.

Please permit us to give our heartfelt thanks to the officers, Board of Trustees, MSNJ staff, all councils and committees of MSNJ, the House Speakers, the AMA delegation, the reference committees of this current House, and the entire House—for the time, effort, and energy expended to make this year successful. We are family! God bless. □



The Reference Committee recommended that the report be filed.
House Action: The report was filed.

Judicial Council

Paul H. Steel, MD
Chairman

Reference Committee on
Constitution and Bylaws/"A"

The Judicial Council presents a summary of its operations and those of county judicial committees for the period February 1991 through January 1992 (Table).

Referral from MSNJ/Board of Trustees (May 13, 1991). *Resolution #15—Interest Rate Charges.* This resolution and the report of legal counsel were reviewed by the Judicial Council. The following is the revision of Opinion #14 as approved by the Council.

Interest Charges. Revised August 22, 1991. A physician who has experienced problems with delinquent accounts may properly choose to add interest or other reasonable billing charges to delinquent accounts. *The patient must be notified in advance* of the interest or service charges by means of posting a notice in the waiting room, the distribution of leaflets in the office, and appropriate notations on billing statements.

Although the Council has reservations regarding this entire mechanism, a charge of 1.5 percent per month is legally permissible. Physicians are encouraged to make exceptions in hardship cases.

The Council does not believe it is appropriate to add attorneys' fees, court costs, or collection costs to the amount owed. If, however, costs and fees are added by court determination, it is appropriate to collect them.

I would like to thank the Medical Society of New Jersey (MSNJ) for allowing me to serve as judicial councilor and Council chairman for the past nine years.

The aim of the Council's work has been to function with quiet efficiency and fairness to all—this, I believe, has been achieved.

I would like to thank my fellow councilors and MSNJ staff—Vincent A. Maressa, Barbara Golfetto, and our retired staff liaison, June A. O'Hare. Absent their help, the job would have been far less enjoyable. □

Table. Summary of operations.

By Judicial Committees	
Complaints reported as disposed of	75
Alleging:	
Dissatisfaction concerning fees	21
Dissatisfaction concerning medical procedures	20
Unprofessional conduct	12
Dissatisfaction concerning professional ethics	22
By Judicial Council	
Meetings held	2
Official communications acted upon	100
Appeal hearings requested	1
Appeal hearings granted	0
Formal opinions revised (Opinion #14)	1

The Reference Committee recommended that the report be filed.
House Action: The report was filed.

AMA Delegation

Karl T. Franzoni, MD
Chairman

Reference Committee on
Constitution and Bylaws/"A"

It is my pleasure to report upon last year's activities of the American Medical Association (AMA) Delegation of the Medical Society of New Jersey (MSNJ).

Meetings. Meetings were held in Chicago, Illinois, on June 23 to 27, 1991, and in Las Vegas, Nevada, on December 8 to 11, 1991.

At the most recent meeting in Las Vegas, there were 442 credentialed delegates, representing 54 states and territories, 81 national medical specialty societies, 5 special sections, and 5 governmental services.

The sites of forthcoming annual meetings are: June 21 to 25, 1992, Chicago, Illinois; June 13 to 17, 1993, Chicago, Illinois; June 12 to 16, 1994, Chicago, Illinois; and June 11 to 15, 1995, Chicago, Illinois.

The sites of the forthcoming interim meetings are: December 6 to 9, 1992, Nashville, Tennessee; December 5 to 8, 1993, New Orleans, Louisiana; December 4 to 7, 1994, Honolulu, Hawaii; and December 3 to 6, 1995, Washington, DC.

Fate of New Jersey resolutions. Two resolutions were introduced by the New Jersey Delegation at the 1991 AMA Annual Meeting in June 1991. The first resolution, "Medicare Notification of Payment," called for the AMA to request the Health Care Financing Administration (HCFA) to direct Medicare Part B carriers to furnish all physicians with an explanation of Medicare benefits (EOMB) on all claims, whether assigned or nonassigned. The second resolution, "Medicare—Home Health Services," called for the AMA to petition Congress and HCFA to authorize adequate reimbursement for home health care case management by physicians under the Medicare program. The resolutions were reaffirmed as existing AMA policy.

Resource-based relative value scale (RBRVS). Modification in the manner of physician reimbursement for services provided to patients represents an ongoing negotiated process, involving all the players, i.e. physicians, patients, hospitals, employers, third-party providers, government. The process of consideration, offer, and counter-offer is capable of and likely will result in periods of acrimony and dissatisfaction. It is, however, a negotiation process that must be undertaken and participated in by all. The AMA constitutes the single national voice to represent your interests. There never has been a more compelling time to justify and to require unity among the members of our profession.

AMA activities concerning this issue are extensively reported elsewhere (*NJ MED* 89:95-98, 1992).

Political activism related to RBRVS. The entire physician community is to be commended for the pressure applied to the federal legislative community relative to this issue. More than 100,000 letters were received by legislators from physicians. Most significant is the fact that this deluge of mail, and additional one-on-one communications, caused Congress to react in our favor. This represents a dramatic example of what unified effort is capable of accomplishing in the political and governmental arena.

HIV testing. Considerable time and effort were spent by the AMA House of Delegates on concerns related to this disease process. There were 19 recommendations, none of which supported mandatory testing of all health care workers.

In other related actions concerning AIDS, the House of

Delegates adopted the following resolutions:

1. That the AMA review the federal laws, including the Veterans' Benefits and Services Act that currently mandates prior written informed consent for HIV testing within the Veteran's Administration Hospital system, and subsequently initiate and support amendments allowing for HIV testing without prior consent in the event that a health care provider is involved in accidental puncture injury or mucosal contact by fluids potentially infected with the HIV virus in federally operated health care facilities.

2. That the AMA support adequate funding and implementation of public health measures to help stop the spread of HIV/AIDS.

3. That all patients who know they are HIV positive should be asked to notify their physician of their HIV-positive status.

4. That the AMA adopt the policy that physicians should be allowed, without explicit informed consent, and as indicated by their medical judgment, to perform diagnostic testing for determination of HIV status of patients suspected of having HIV infection.

5. That the AMA adopt the policy that general consent for treatment of patients in the hospital be accepted as adequate consent for the performance of HIV testing.

6. That the AMA develop model state and federal legislation, and work with the Centers for Disease Control (CDC) to permit physicians, without explicit informed consent, and as indicated by their medical judgment, to perform diagnostic testing for determination of HIV status of patients suspected of having HIV infection.

7. That the AMA reaffirm its policy that the denial of care within the expertise of the individual physician on the basis of a patient's HIV status is a violation of medical ethics (Council on Ethical and Judicial Affairs, Report A, I-87).

8. That the AMA study the problems for health care workers that stem from apparent conflicts in laws between informed consent on one side and privacy, confidentiality, and employment discrimination on the other side.

Campaign against family violence and violence against women. There will be more widespread emphasis upon increased awareness of these issues.

Finances and dues. The AMA is fiscally sound. Dues remain at $400. This represents the fourth year without a raise in dues.

Size of AMA House of Delegates. There is a developing, broadening concern about the ever-enlarging size of the AMA House of Delegates. As noted, its present size is 442 delegates. The number of 500 delegates currently is considered to represent a size of concern and, if and when reached, could represent a time at which the state society representation of one delegate per one thousand members could conceivably be modified.

Conclusion. This represents the final annual report provided by me, as chairman. I am most grateful for the opportunity to serve MSNJ. You have selected individuals with outstanding qualifications to represent you at a national level. All the delegates work assiduously to represent your interests. You are their constituency, and they remain constantly available to you for input, guidance, and direction. □

The Reference Committee recommended that the report be filed.
House Action: The report was filed.

Committee on Long-Range Planning and Development

Edward A. Schauer, MD
Chairman

Reference Committee on
Constitution and Bylaws/"A"

Meetings of the Committee on Long-Range Planning and Development were held on May 23, 1991, September 20, 1991, and January 8, 1992. The Committee's major activity for the year was to guide implementation of the findings that emerged from the previous year's survey of all Medical Society of New Jersey (MSNJ) councils and committees.

In response to recommendations from the Committee, the Board of Trustees took actions in July 1991, based on the survey findings (Table).

The Committee plans to study each council and committee's success in meeting its objectives, as articulated in the Committee's 1990 report. A retreat could serve as the venue for outlining such a study.

Committee members have expressed special concern about assuring MSNJ's responsiveness to county societies and to resolutions of the House of Delegates. Accordingly, the Committee adopted the following recommendations in January 1992 that will be considered by the Board of Trustees.

1. "That the Board of Trustees set up a mechanism to categorize and review all the policies of the Society and make them part of the policy manual and then evaluate each incoming resolution to the House of Delegates in terms of its conformance with the policy manual."

2. "That the House of Delegates authorize the appointment of an Oversight Committee of the House to evaluate, on an annual basis, the previous year's resolutions of the House and report to the House on the results of its efforts."

The Committee also considered whether to recommend development of a regionalized structure for county medical societies. The Committee decided not to pursue this concept; instead, MSNJ could offer assistance to county societies that lack full-time staff. □

Table. Committee recommendations.

Subject	Recommendation	Board Action
Committee on Young Physicians	Redefine goals and structure	Postpone, pending information from county societies
Committee on Emergency Medical Services	Consolidate into Council on Public Health	Approved
Council on Medical Services	Redefine, due to formation of diverse ad hoc groups	Approved
Legal Assistance Program for Members	Consider establishing	Referred to Committee on Membership Services

The Reference Committee recommended that the report be filed.
House Action: The report was filed.

Committee on Physicians' Health

Simon Murray, MD
Chairman

Reference Committee on
Constitution & Bylaws/"A"

During the past year, the Physicians' Health Program has continued to serve the medical profession in New Jersey. The major activity of the Program continues to be the identification, rehabilitation, and monitoring of physicians diagnosed with diseases of impairment (alcoholism, other chemical dependencies, psychiatric diagnosis, dementia, or physical/neurological disabling conditions).

The recognition and acceptance of the Program continues to grow as more physicians successfully are treated and returned to active practice, as healthy, productive, skilled physicians.

On both national and international levels, our Program continues to be in the forefront in dealing with professional impairment. Our staff is asked to consult with and train program leadership in many states as well as in Canada. Our Program continues to play a leadership role in the National Federation of State Physician Health Programs.

During the past year, our prevention/education efforts have focused primarily on lecturing to UMDNJ staff, various hospital personnel at grand rounds and staff meetings, residency training programs, and other medical audiences. On May 22, 1991, we organized the annual conference, "Issues in Chemical Dependency" with nationally recognized speakers.

The Medical Society of New Jersey (MSNJ) has challenged, in the courts, the renewal application of State Board of Medical Examiners that would have shown prejudice against many of our successfully rehabilitated physicians. The Physicians' Health Program thanks MSNJ for its support of this concern of our Program. While preliminary court procedures seem to be in favor of the Board position, MSNJ continues to work on behalf of our members and Program participants.

An important component of successful recovery is the financial need of individuals to pay for appropriate care, to feed and house their families during their absence from practice, and to pay critical bills, e.g. malpractice insurance, during re-entry into practice. While the Physicians' Health Program cannot pay all of these expenses, the Treatment Loan Fund and the Grant Fund

Table. ***Statistical report.***

September 7, 1982-December 7, 1991

	1982	1983	1984	1985	1986	1987	1988	1989	1990	1991	Total
Primary Impairment											
Alcohol	14	40	19	31	31	18	16	22	25	25	241
Drug	25	16	22	24	25	20	21	24	18	16	211
Psychiatric	7	18	19	19	14	15	9	18	18	11	148
Senility	1	5	3	2	–	–	1	1	2	–	15
Personality disorder	–	1	–	–	2	1	–	2	–	2	8
Other	1	1	8	7	4	3	5	13	2	11	55
Annual total	48	81	71	83	76	57	52	80	65	65	678

continue to provide help to many of our Program participants. Due to the Annual Raffle, the Grant Fund netted an increase of $37,127.20. (From 1985 to 1991, 113 grants were given to 83 individuals, totalling $87,243.70.) MSNJ Auxiliary participation in the work of the Program continues. The Annual Food Pantry/ Holiday Gift program is conducted by the MSNJ Auxiliary.

The statistical breakdown for the program through December 31, 1991, is listed in the Table. These statistics do not reflect ongoing success, only the raw data. Additional publications will be made available to the members of MSNJ, upon request, concerning the nine-year outcome survey regarding success among our chemically dependent program participants. The work of the Physicians' Health Program is not based upon statistics, it is about the lives and careers of those who practice the art of medicine. Our work is about physicians and physician family members who are freed from diseases that isolate and destroy families and careers. Our Program is about healing the healers. □

The Reference Committee recommended that the report be filed.
House Action: The report was filed.

Committee on Revision of Constitution and Bylaws

ames E. George, MD, JD
Reference Committee on
Constitution and Bylaws/"A"

Proposed Amendment to the Bylaws—Mail Balloting. The Committee on Revision of Constitution and Bylaws was requested by the Board of Trustees to consider the issue of conducting a mail ballot of the House of Delegates when a single issue arises, instead of convening the entire House.

The Committee on Revision of Constitution and Bylaws recommends adoption of the Bylaw proposal:

(c) Rules of Order
Same

(d) Registration and Identification
Same

(e) General Sessions and Section Meetings
Same

(c) Mail Balloting

A mail balloting may be conducted by the House of Delegates in lieu of a special meeting for a particular purpose.

Mail ballots shall be devoted to any issue or issues and may only be initiated by the Board of Trustees.

In order for a proposed action to be effective, 51 percent of the ballots sent to delegates must be returned and clearly marked in favor of the proposal.

(d) Rules of Order
Same

(e) Registration and Identification
Same

(f) General Sessions and Section Meetings
Same

The Reference Committee felt that if an issue was to arise that could not be handled by the Board of Trustees, a special session of the House of Delegates should be convened since the Board acts on behalf of the House. This would give the delegates an opportunity to discuss and debate the issue.

The Reference Committee recommended that the proposed amendment to the Bylaws not be adopted.

House Action: The proposed amendment was not adopted.

The Reference Committee recommended that the report be filed.

House Action: The report was filed.

Resolutions

Resolution #1

Introduced by: Union County Medical Society
Subject: Ethics of Self-Referral
Referred to: Reference Committee on Constitution and Bylaws/"A"

Whereas, the American Medical Association (AMA) Council on Ethical and Judicial Affairs has decreed that physicians should avoid referrals to off-premise medical facilities in which they have a financial interest; and

Whereas, the matter was presented to the AMA House of Delegates in a manner that permitted no discussion; and

Whereas, physicians have invested in off-premise medical facilities to provide better and more convenient medical facilities for their patients; and

Whereas, physicians do inform their patients of their ownership interests and provide names of alternate facilities; now therefore be it

~~**Resolved,** that the Medical Society of New Jersey (MSNJ) adopt the policy that a physician's referral to an off-site medical facility in which he has a financial interest is an ethical referral, as long as the patient is fully informed of the ownership/interest and alternate facilities (if available) are named; and be it further~~

~~**Resolved,** that the AMA delegation of MSNJ present a similar resolution to the AMA House of Delegates.~~

Resolved, that MSNJ adopt the policy that a physician's referral to an off-site medical facility in which he has a financial interest is an ethical referral, as long as the patient is fully informed of the ownership/interest and alternate facilities (if available) are named; and be it further

Resolved, that the AMA delegation of MSNJ present a similar resolution to the AMA House of Delegates; and be it further

Resolved, that the State Board of Medical Examiners be informed of MSNJ's position on this matter.

The Reference Committee recommended that Resolution #1 be adopted.

House Action: Resolution #1 was adopted as amended by the House of Delegates.

Resolution #8

Introduced by: Middlesex County Medical Society
Subject: Proportionment of AMA Delegate and Alternate Delegate Positions
Referred to: Reference Committee on Constitution and Bylaws/"A"

Whereas, there are 21 county medical societies chartered under the Medical Society of New Jersey (MSNJ); and

Whereas, there are five regional districts within the state; and

Whereas, the election of trustees and judicial councilors is based on regional district representation; and

Whereas, there appears to be several delegates and/or alternates from a few counties; now therefore be it

Resolved, that the election of American Medical Association (AMA) delegates and alternates, in fairness to all, be based on MSNJ judicial districts; and be it further

Resolved, that if the number of allotted delegates and alternates, or a portion thereof, cannot be allocated evenly by judicial district, then the remainder shall be elected on an "at-large" basis.

The Reference Committee recommended that Resolution #8 be rejected.

House Action: Resolution #8 was rejected.

Resolution #13

Introduced by: Passaic County Medical Society
Subject: Two-Year Term for MSNJ President
Referred to: Reference Committee on Constitution and Bylaws/"A"

Whereas, the Bylaws of the Medical Society of New Jersey (MSNJ) [Chapter V, Section 1 (a)] restrict the president of MSNJ to a single, one-year term; and

Whereas, a considerable period of time generally is needed to settle into this office and to function efficiently and effectively; and

Whereas, the ability to remain in this office for more than one year will enhance the leadership of MSNJ; now therefore be it

Resolved, that MSNJ amend its Bylaws [Chapter V, Section 1 (a)] to permit an incumbent president to seek re-election to that office one time at the conclusion of his/her first term as president.

The Reference Committee recommended that Resolution #13 be rejected.

House Action: Resolution #13 was rejected.

Resolution #18

Introduced by: Frank J. Primich, MD, Delegate, Hudson County
Subject: Alternative to National Health Insurance
Referred to: Reference Committee on Constitution and Bylaws/"A"

Whereas, the American Medical Association's (AMA) Health Access America leaves much to be desired; and

Whereas, support from the likes of Senator Edward Kennedy is cause for due concern; and

Whereas, proposals by the presidential candidates are even more alarming; and

Whereas, rational alternatives are being proposed by the National Center for Policy Analysis; now therefore be it

Resolved, that the Medical Society of New Jersey (MSNJ) support the program proposed by the National Center for Policy Analysis; and be it further

Resolved, that said plan be recommended to the AMA for endorsement and support.

The Reference Committee acknowledged the importance of the issue raised in Resolution #18, and noted that the action called for in Resolution #18 may represent a substantial change in MSNJ's policy that supports Health Access America.

The Reference Committee recommended that Resolution #18 be referred back to the Board of Trustees for study and report to the House of Delegates no later than the 1993 Annual Meeting.

House Action: Resolution #18 was referred back to the Board of Trustees for study and report.

Resolution #22

Introduced by: Bergen County Medical Society
Subject: Guidelines/Standards for Physician Advertising
Referred to: Reference Committee on Constitution and Bylaws/"A"

Whereas, physician advertising has increased in recent years; and

Whereas, patients depend on physicians to be honest and professional in advising on health care needs (as contrasted to some commercial vendors who advertise solely as an inducement to buy); now therefore be it

~~**Resolved,** that the Medical Society of New Jersey (MSNJ) shall *in conjunction with the State Board of Medical Examiners* formulate guidelines and standards for advertising of medical/surgical practices so that any such advertisement will be honest and will act in the best interest of patients and the public.~~

Resolved, that MSNJ shall formulate guidelines and standards for advertising of medical/surgical practices so that any such advertisement will be honest and will act in the best interest of patients and the public; and be it further

Resolved, that after the guidelines and standards are formulated by MSNJ, they be forwarded to the State Board of Medical Examiners for consideration and appropriate amendment.

The Reference Committee recommended that Resolution #22 be adopted as amended (deletion of the word "shall" and addition of italics as the amendment).

House Action: Resolution #22 was adopted as amended by the House of Delegates.

Resolution #24

Introduced by: Bergen County Medical Society
Subject: Changing the Emphasis of *NEW JERSEY MEDICINE*
Referred to: Reference Committee on Constitution and Bylaws/"A"

Whereas, physicians need information relevant to a wide range of topics involving legal, insurance, and business issues; now therefore be it

Resolved, that the Medical Society of New Jersey encourage the editorial staff of *NEW JERSEY MEDICINE,* the journal of the Medical Society of New Jersey, to emphasize topics involving legal, insurance, and business issues on an ongoing basis so that the journal will be a consistent, reliable source of information.

The Reference Committee was of the opinion that Doctor Howard D. Slobodien, editor-in-chief of *NEW JERSEY MEDICINE,* and the editorial staff are doing a fine job and should be commended for their efforts.

The Reference Committee recommended that Resolution #24 be rejected.

House Action: Resolution #24 was rejected.

Resolution #25

Introduced by: Ocean County Medical Society
Subject: AMA's Renouncing of RBRVS
Referred to: Reference Committee on Constitution and Bylaws/"A"

Whereas, the final rules for the Medicare Program Fee Schedule (MPFS) are based on erroneous malpractice and overhead data; and

Whereas, the entire tenor of the MPFS is aimed at an unfair reduction in payments to physicians; and

Whereas, MPFS unjustly discriminates against newly qualified physicians; and

Whereas, an evaluation of the fee structure for procedures in most instances reveals gross inconsistencies, where a lesser fee is allocated to a more complicated operation; and

Whereas, the Harvard study is patently flawed or incomplete; and

Whereas, unreasonable bundling denies reasonable payment for services rendered; now therefore be it

~~**Resolved, that the Medical Society of New Jersey (MSNJ) instruct its delegation to the American Medical Association (AMA) to petition that body to openly renounce the resource-based relative value scale (RBRVS) and to actively campaign for its repeal.**~~

Substitute Resolution

Resolved, that MSNJ instruct its AMA delegates to request the AMA to continue its efforts to refine, readjust, and eliminate the inequities of RBRVS, keeping in mind that it is a payment allocation schedule and not a fee schedule.

The Reference Committee recommended that a substitute resolution be adopted.

House Action: Substitute Resolution #25 was adopted.

Resolution #31

Introduced by: Hudson County Medical Society
Subject: Behavioral Offset Adjusted Basis Reduction
Referred to: Reference Committee on Constitution and Bylaws/"A"

Whereas, the resource-based relative value scale (RBRVS) was calculated to offer a fair schedule of reimbursement for physicians' services, although often at reduced amounts, according to multiple factors designed to maintain an overall "budget neutral" status; and

Whereas, subsequent calculations further reduced reimbursement by a behavioral adjustment factor, later renamed an adjusted basis, to offset anticipated increasing of services to compensate for reduced fees (a prediction that is insulting and denigrating to physicians); now therefore be it

~~**Resolved,** that the Medical Society of New Jersey (MSNJ) request that the Health Care Financing Administration (HCFA) reconsider and recalculate the conversion factor; and be it further~~

~~**Resolved,** that the American Medical Association (AMA) be requested to urge HCFA to reconsider and to increase the conversion factor consistent with statutory standards.~~

Resolved, that MSNJ request that HCFA reconsider and increase the conversion factor; and be it further

Resolved, that the AMA be requested to urge HCFA to reconsider and increase the conversion factor consistent with statutory standards; and be it further

Resolved, that MSNJ petition HCFA to eliminate the behavioral offset adjustment factor.

The Reference Committee recommended that Resolution #31 be adopted.

House Action: Resolution #31 was adopted as amended by the House of Delegates.

Resolution #33

Introduced by: Hudson County Medical Society
Subject: Limited-License Practitioners
Referred to: Reference Committee on Constitution and Bylaws/"A"

Whereas, limited-license practitioners increasingly have had their scopes of practice expanded by legislative fiat or by licensing board regulations; and

Whereas, this is exemplified by recent acts of the New Jersey Legislature regarding optometrists, physician assistants, and nurses; now therefore be it

Resolved, that the Medical Society of New Jersey (MSNJ) request the American Medical Association (AMA) to study quality of care and economic issues related to delivery of health care by nonphysicians.

The Reference Committee recommended that Resolution #33 be adopted.

House Action: Resolution #33 was adopted.

Resolution #35

Introduced by: Hudson County Medical Society
Subject: Medicare Fees Under RBRVS
Referred to: Reference Committee on Constitution and Bylaws/"A"

Whereas, the Medicare program was intended to improve access of its beneficiaries to medical care; and

Whereas, since 1984, Medicare reimbursement fees have first been frozen and then progressively and, at times drastically diminished, first as MAACs, then as limiting charges; and

Whereas, the approved Medicare amounts for certain medical services and procedures, at times, are less than such payment of 15 years ago in actual dollar amounts (not adjusted for inflation); and

Whereas, the cost to the physician to provide health care, i.e. the overhead of a medical practice, continues to increase annually; and

Whereas, the current Medicare fees under the resource-based relative value scale (RBRVS) will financially strain the physician to the point of limiting and eventually denying access of the Medicare patient to medical services; now therefore be it

Resolved, that the Medical Society of New Jersey (MSNJ) continually petition federal legislators to reverse the trend of diminished physician reimbursement that eventually will deny access of Medicare patients to medical care; and be it further

Resolved, that MSNJ work through the public media to inform the Medicare population of the actions of Congress and the Health Care Financing Administration (HCFA) that will label Medicare beneficiaries as "second-class patients" and, hence, limit or deny their access to the care that they need and deserve; and be it further

~~**Resolved,** that Resolution #35 be forwarded to the American Medical Association (AMA).~~

Resolved, that the AMA House of Delegates be requested to adopt a similar resolution.

The Reference Committee recommended that the third resolved be amended.

The Reference Committee recommended that Resolution #35 be adopted as amended by the Reference Committee.

House Action: Resolution #35 was adopted as amended by the Reference Committee.

Resolution #38E

Introduced by: Ocean County Medical Society
Subject: Resolution To Revoke State Board of Medical Examiners Regulation *N.J.A.C. 13:35-6.16*—Professional Practice Structure Item Regulation *6.17*
Referred to: Reference Committee on Constitution and Bylaws/"A"

Whereas, physicians who take the Hippocratic oath are the patients' ombudsmen and act in the best interest of their patients; and

Whereas, as a profession, medicine is esteemed and draws into its ranks people of the highest moral and ethical character; and

Whereas, in the United States of America one is deemed innocent until proved guilty; and

Whereas, the State Board of Medical Examiners (SBME) regulation *N.J.A.C. 13:35-6.16*—Professional Practice Structure Item, *6.17,* that a licensee may only charge his own actual cost plus 10 percent for medications, medical goods, and medical devices, implies that physicians are not worthy of the trust bestowed upon them by society and are by nature avaricious to the point of overcharging and guilty of dispensing unnecessary devices and therapy; and

Whereas, by omission, this regulation insinuates that other enterprises, suppliers, and health care givers are of a higher moral and ethical character; now therefore be it

Resolved, that the Medical Society of New Jersey (MSNJ) do all in its power to have SBME overturn *N.J.A.C. 13:35-6.16* and *6.17;* and be it further

~~**Resolved,** that if the MSNJ is unable to overturn this regulation, that it petition the Legislature to extend its regulations to all providers of health care services and material to create a level playing field.~~

Resolved, that if MSNJ is unable to get SBME to overturn this regulation, that MSNJ petition the Legislature to correct this unfair and inequitable regulation.

The Reference Committee recommended that the second resolved be amended.

The Reference Committee recommended that Resolution #38E be adopted as amended by the Reference Committee.

House Action: Resolution #38E was adopted as amended by the Reference Committee.

Resolution #40E

Introduced by: Burlington County Medical Society
Subject: State Board of Medical Examiners Regulations *N.J.A.C. 13:35-6.16* and *6.17*
Referred to: Reference Committee on Constitution and Bylaws/"A"

Whereas, the New Jersey State Board of Medical Examiners (SBME) has adopted new regulations, *N.J.A.C. 13:35-6.16* and *6.17;* and

Whereas, these regulations restrict a practicing ophthalmologist from charging more than his supply cost plus 10 percent and no allowance is made for recovery of overhead and other significant administrative costs; and

Whereas, the obvious economic realities resulting from regulations will force ophthalmologists to stop dispensing eyewear to their patients; and

Whereas, patients then will find themselves faced with higher costs, lower quality, and greatly reduced convenience by being forced to seek their dispensing needs elsewhere; and

Whereas, these regulations apply only to ophthalmologists, and not to optometrists or opticians who also dispense eyewear in a similar fashion; now therefore be it

Resolved, that the Medical Society of New Jersey (MSNJ) actively oppose the new regulations of SBME *(N.J.A.C. 13:35-6.16* and *6.17),* and pursue all available avenues for their repeal.

The Reference Committee recommended that Resolution #40E be adopted.

House Action: Resolution #40E was adopted.

Secretary

Bernard Robins, MD
Reference Committee "B"

The office of the Secretary has continued its usual routines, primarily involving maintenance of membership records, correspondence, minutes of Board of Trustees' meetings, telephone inquiries, and completion of various questionnaires.

During the administrative year, the secretary attended the meetings of the Board of Trustees and the several committees of which he is chairman, member, or advisor.

Membership statistics are shown in Table 1.

A comparison of December 31, 1990, to December 31, 1991, by county shows the following net changes of active paid membership:

Atlantic	0
Bergen	+19
Burlington	— 2
Camden	— 7
Cape May	+ 8
Cumberland	+ 7
Essex	+ 5
Gloucester	+ 4
Hudson	—11
Hunterdon	+ 6
Mercer	0
Middlesex	— 9
Monmouth	+ 9

Table 1. ***Membership (as of December 31, 1991).***

Active	Paid	7,361		
	Exempt	771		
Resident	Paid	118		8,250***
*Associate	Paid			41
**Affiliate	Paid			63
State Emeritus			1,172	
Total of above			9,526	
Provisional Residents (six months)			11	
Student Members			120	
State Honorary (living)			1	
New and Reinstated Members				
Active			571	
Resident			40	
*Associate			28	
Transfers within the state			31	
Transfers out-of-state and resignations			82	
Members deceased			122	
Members dropped			259	
Active:				
a. Nonpayment of dues		184		
b. Did not comply with bylaw requirements regarding continuing medical education, whose credits were due in 1990		30		
c. New Jersey license suspended		1		
d. New Jersey license voluntary surrendered		1		
Resident (nonpayment of dues)		25		
*Associate (nonpayment of dues)		4		
**Affiliate (nonpayment of dues)		14		

*Associate membership (nonlicensed in New Jersey) designates interns and residents.
**Affiliate membership designates physicians who no longer practice in New Jersey.
***Adjusted for transfers out-of-state, resignations, and deaths.

Morris	+ 9
Ocean	0
Passaic	—16
Salem	— 5
Somerset	— 6
Sussex	— 3
Union	—10
Warren	+ 2

AMA Membership. There are 9,020 New Jersey licensed physicians maintaining active membership in the AMA. The Society's representation in the AMA House of Delegates stands at ten delegates—one for each one thousand members, or fraction thereof.

Credentials. The Committee on Credentials reviewed and acted upon membership applications and their supporting credentials as submitted through the component societies. The statistical breakdown in Table 2 reflects the Committee's activities during the period February 1, 1991, through January 31, 1992.

The Committee extends appreciation to the directors and the secretaries of component societies, and to those who assist them, as well as the county credentials committees, for their cooperation in processing membership applications. Those who process credentials in the component societies should call specific attention to any deficiencies or questionable data on the application form being submitted to the Credentials Committee of the Medical Society of New Jersey. This procedure will insure more accurate and speedy evaluation of credentials. The chairman wishes to thank his Committee members for their diligence and cooperation.

Table 2. ***Statistical breakdown.***

Received	Provisional *Associate	Residents Licensed	Active	Grand Total
	26	22	398	446
Reviewed and found	**Provisional *Associate**	**Residents Licensed**	**Active**	**Grand Total**
(A) Satisfactory	26	22	373	421
(B) Unsatisfactory	0	0	0	0
Pending:	0	0	16	16
Withdrew:	0	0	9	9
Grand Total	26	22	398	446

*Associate membership (nonlicensed in New Jersey) designates interns and residents.

Membership Directory. The 1991 edition of the *Membership Directory* has been available for one year. Since the original distribution of 9,966 copies to members, 1,667 copies have been sold to others. It is anticipated that data sheets for the 1993 edition will be mailed to members in September 1992. Your cooperation in returning them promptly will be greatly appreciated. □

The Reference Committee recommended that the report be filed.
House Action: The report was filed.

Treasurer

Gerald H. Rozan, MD
Reference Committee "B"

These interim financial statements, prepared in accordance with generally accepted accounting principles, reflect the financial position and results of operation of the Medical Society of New Jersey (MSNJ) through February 29, 1992.

Since they are interim statements (MSNJ's fiscal year is June 1 through May 31), the figures are unaudited. A complete audit will be conducted of the books of MSNJ as of May 31, 1992, and an audited report prepared as of that date. A complete audit was made, and copies sent to all county medical societies, for the fiscal year that ended May 31, 1991.

Balance Sheet
February 29, 1992
(Unaudited)

Assets		
Cash		$ 576,776
Investment in money market fund		2,249,749
Marketable securities—(approximate market)		1,158,456
Accounts receivable—member assessments		472,412
Medical student loans (net allowance for doubtful loans of $20,000)		182,623
Property, Plant, and Equipment		
Land	$ 150,000	
Building and improvements	5,444,662	
Furniture and fixtures	589,196	
	6,183,858	
Less allowance for depreciation	(1,372,397)	4,811,461
Prepaid expenses		76,822
Other assets		418,456
Investment in New Jersey State Medical Underwriters, Inc.		30,339
		$9,977,094
Liabilities and Fund Balance		
Accounts payable and accrued expenses		$ 443,229
Assessments collected for AMA		24,145
		467,374
Mortgage payable		3,955,977
Deferred revenue from member assessments		2,129,735
Deferred revenue—public relations assessments		4,610
Deferred revenue—other		202,901
Fund Balance		3,216,497
		$9,977,094

Statement of Revenue and Expenses
9 Months Ended February 29, 1992
(Unaudited)

Revenue		
Membership dues		$1,819,130
Publication sales and advertising income		217,869
Amortization of Physicians' Health Program		202,319
Amortization of public relations assessment		91,000
Investment income		146,610
Royalty income		193,086
Rental income		474,357
Annual Meeting		36,050
Membership Directory sales		31,674
Other income		25,307
	Total Revenue	3,237,402
Expenses		
Conferences and meetings		421,954
Member services		729,058
		1,151,012
General and administrative		1,637,773
Interest		271,672
Depreciation		129,553
	Total Expenses	3,190,010
Excess of revenue over expenses before federal income tax		$ 47,392
Provision for federal income tax		(75,006)
		(27,614)
Equity in income (loss) of unconsolidated subsidiary		712
Excess of revenue over expenses (expenses over revenue)		(26,902)
Fund balance at June 1, 1991		3,243,399
Fund balance at February 29, 1992		$3,216,497

The Reference Committee recommended that the report be filed.
House Action: The report was filed.

Finance and Budget

Matis A. Fermaglich, MD
Chairman
Reference Committee "B"

The Committee on Finance and Budget met on Wednesday, March 25, 1992, for the purpose of reviewing the proposed budget for the 1992-1993 fiscal year.

The proposed budget and the following recommendations were approved by the Board of Trustees on April 15, 1992, and are submitted to the House of Delegates for approval.

1. That the budget for the fiscal year beginning June 1, 1992, and ending May 31, 1993, in the amount of $4,271,000 with $2,595,000 to be raised through member assessments and $79,000 to be funded through a draw down on standing reserves of the Society, be adopted.

2. That the 1993 assessment be set at $375 per regular dues-paying member. (Four preceding years were $350.)

3. That the 1993 assessment be set at $60 per member for affiliate members (no longer practicing in New Jersey). (No change from prior year.)

4. That the 1993 assessment for associate members (interns-residents nonlicensed in New Jersey) and licensed residents, provided the individual is in a residency program entered upon within a reasonable time after graduation from medical school, be set at $25. (No change from prior year.)

5. That the 1993 assessment be set at $10 per student for medical students. (No change from prior year.)

The Reference Committee recommended the approval of recommendations 1 through 5.

House Action: The recommendations were approved.

Statement of Revenue and Expenses
Proposed Budget
Fiscal Year Ending May 31, 1993

Revenue (other than member assessments)		
Publication sales and advertising income		$ 231,000
Amortization of Physicians' Health Program		288,000
Investment income		80,000
Royalty income		265,000
Rental income		633,000
Annual Meeting		15,000
Membership Directory sales		75,000
Other income		10,000
	Total Revenue	$1,597,000
Expenses		
Conferences and meetings		426,000
Member services		657,000
Publications		319,000
	Total Program Expenses	$1,402,000
General and administrative		2,339,000
Interest		350,000
Depreciation		180,000
	Total Expenses	$4,271,000
Total of expenses over revenue to be raised through member assessments and a charge against standing reserves of the Society.		$2,674,000

Revenue from member assessments
Fiscal year ending May 31, 1993

(7 months) 6/1/92 through 12/31/92 @ $350 x 7,200 members =	$1,469,992
(5 months) 1/1/93 through 5/31/93 @ $375 x 7,200 members =	1,125,008
	$2,595,000
Charge against standing reserves of the Society	79,000
	$2,674,000

Proposed Budget Fiscal Year Ending May 31, 1993	Approved Budget 1991/92	Estimate for Y/E 5/31/92	Proposed Budget 1992/93
Compensation			
Salaries	$1,230,000	$1,200,000	$1,209,000
Pension plan	125,000	125,000	128,000
	1,355,000	1,325,000	1,337,000
Professional Fees			
Audit	24,000	29,000	28,000
Legal	110,000	110,000	125,000
Actuarial	4,000	6,000	6,000
Special consultants	10,000	10,000	32,000
	148,000	155,000	191,000
Councils and Committees			
Public relations	273,000	390,000	200,000
Public relations—special assessment	100,000	93,000	—
Legislation*	88,000	85,000	155,000
President and presidental officers	75,000	77,000	75,000
AMA delegates	90,000	80,000	90,000
MSNJ Auxiliary	30,000	30,000	30,000
Medical education	30,000	30,000	32,000
Board of Trustees*	35,000	56,000	121,000
Judicial Council	1,000	1,000	1,000
Reimbursement of reps. to mtgs.	2,000	2,000	2,000
Other councils and committees	40,000	35,000	40,000
Medical Student Association	10,000	8,000	10,000
Grant allocation—MIIX	(330,000)	(330,000)	(330,000)
	444,000	557,000	426,000
Member Services			
Physicians' Health Program	408,000	380,000	413,000
Annual Meeting	140,000	160,000	162,000
Professional Liability	90,000	92,000	39,000
Membership Directory	47,000	28,000	43,000
	685,000	660,000	657,000
Publication			
NEW JERSEY MEDICINE	320,000	317,000	319,000
General Administrative & Operating Expenses			
Building operations—(including depreciation)	728,000	729,000	735,000
Insurance	203,000	193,000	217,000
Payroll taxes	95,000	98,000	98,000
Other general office costs	286,000	264,000	291,000
	1,312,000	1,284,000	1,341,000
TOTAL	$4,264,000	$4,298,000	$4,271,000

*Increase in Legislation and Board of Trustees' accounts due to ongoing expenses charged to "Public relations—special assessment" in prior years.

The Reference Committee recommended that the report be filed.
House Action: The report was filed.

Council on Mental Health

Council on Legislation referral—A-4001—Martin: State Psychiatric Study Commission. The Council on Mental Health objected to the composition of the Commission. There is no mandate for professionals or psychiatrists to be represented on the Commission. The Council felt the composition should be more specifically representative of both medicine and psychiatry. Therefore, the Council takes the position of support with amendment to add a psychiatrist to the Commission.

Green Spring of New Jersey utilization review criteria. After reviewing the criteria, the Council recommended the following: "That the Board of Trustees refer the issue of managed care concerning psychiatric patients to the Council on Public Relations. The Council on Mental Health would request the help and cooperation of the Council on Public Relations to educate the public."

AMA/psychiatric benefits for members—access to care under national health insurance. The Council was informed that the AMA has issued a Health Access America Plan. There were not any provisions made in the Plan for psychiatric benefits. Various states worked to include mental health benefits in the Plan.

After discussion, the Council submitted the following recommendation: "That the Board of Trustees urge the AMA to include in the Health Access America Plan the following psychiatric benefits at parity with other medical benefits: schizophrenia, schizo-affective disorder, bipolar disorder, delusional depression, and pervasive developmental disorder, as well as other life-threatening or gravely disabling mental disorders where there is a threat to the life of the patient or others, e.g. suicidal patients, severe anorexia." Subsequently, the Board of Trustees referred the item back to the Council for clarification and refinement. □

Thomas Houseknecht, MD
Chairman
Reference Committee "B"

The Reference Committee recommended that the report be filed.
House Action: The report was filed.

Council on Public Health

Charles J. Moloney, MD
Chairman
Reference Committee "B"

The Council on Public Health is responsible for coordinating activities of the Committee on Environmental Health, Committee on Cancer Control, and Committee on Conservation of Vision, in addition to exercising its own initiative on subjects that are important to public health.

On October 16, 1991, the Council considered actions involving Lyme disease, AIDS prevention, standards for mercury and heavy metal contamination, pending legislation on Agent Orange, and diverse recommendations of the Committee on Cancer Control. The disposition of these matters is summarized in the Table.

In January 1992, the Council on Public Health held an informal meeting, requested by the New Jersey State Department of Health (NJDOH), to discuss issues related to the appearance of new, multiple-drug-resistant strains of tuberculosis, especially among HIV-positive populations. Council members planned to monitor the situation and requested additional information from NJDOH. □

Issue	Proposal to Council	Council Action	Board Action
Lyme disease	NJDOH task force sought support	Recommend article to be published in *NEW JERSEY MEDICINE*	Not approved (July 1990 *NEW JERSEY MEDICINE* devoted to Lyme disease)
AIDS	Staff proposed project for school education	Discuss; general support given	None requested
Heavy metal air pollution	Committee on Environmental Health proposed recommendation that state base standards on health, not on technology	Endorse	Referred back to Committee on November 17, 1991; approved on January 19, 1992
Mercury contamination	Committee on Environmental Health proposed recommendation that state base standards on health, not on technology	Endorse	Referred back to Committee on November 17, 1991; approved on January 19, 1992
Off-label drug uses	Committee on Cancer Control asks for recommendation for federal support of off-label uses	Forward without recommendation	Referred back to Committee on December 15, 1991
Cancer screening	Committee on Cancer Control asks state legislation for insurance reimbursement	Forward without recommendation	Approved
Cancer research	Committee on Cancer Control asks support for New Jersey research on breast cancer research project	Forward without recommendation	Approved

The Reference Committee recommended that the report be filed.
House Action: The report was filed.

Committee on Annual Meeting

Donald J. Holtzman, MD
Chairman
Reference Committee "B"

The reorganizational meeting of the Committee on Annual Meeting was held on June 12, 1991, at the executive offices in Lawrenceville. After an indepth discussion it was agreed to hold the Annual Meeting at the Trump Taj Mahal Casino/Resort in Atlantic City from Saturday, May 2, 1992, through Wednesday, May 6, 1992. This was approved by the Medical Society of New Jersey Board of Trustees.

At the present time, the Board of Trustees will meet at 3:30 P.M. on Saturday, May 2. On Sunday, May 3, registration will open at 8:00 A.M. and there will be an educational program at 10:00 A.M. regarding the resource-based relative value scale. The Academy of Medicine of New Jersey will conduct the Academy Lecture at 12:15 P.M., entitled, "Old Problems, New Rules: The Effects of Federal and State Advance Directive Legislation on Clinical Practice." The exhibits will open at 11:30 A.M. and the first session of the House of Delegates will meet at 2:00 P.M. Reference committees will meet at 3:30 P.M.

On Monday, May 4, there will be a prayer breakfast, "Death With Dignity," at 7:30 A.M. The House of Delegates will meet at 9:00 A.M., the Golden Merit Awards Ceremony and Reception will start at 12 NOON, and Reference Committees will meet at 2:30 P.M. The JEMPAC Political Forum and Wine and Cheese Reception will be held at 5:00 P.M.

On Tuesday, May 5, the House of Delegates will meet at 9:00 A.M. The exhibits will close at 2:00 P.M. and the Inaugural Reception and Dinner-Dance honoring incoming President William E. Ryan, MD, will be at 7:00 P.M.

On Wednesday, May 6, there will be an educational program, "The Expanding Clinical Spectrum of HIV Disease," at 8:30 A.M., and a program at 9:30 A.M., "Physicians, Their Hearts, and Type A Coronary Prone Behavior"; several eminent speakers will discuss the subject. The Board of Trustees will meet at 1:00 P.M.

The Society is arranging to have a meeting-hospitality area available for the delegates and the county society executives when Society functions are not scheduled. Arrangements are being made to have an area available Sunday and Monday, May 3 to 4, from 6:00 P.M. to 9:00 P.M.

We look forward to good attendance at this meeting. To our knowledge, the Annual Meeting does not conflict with the meetings of other major medical organizations. □

The Reference Committee recommended that the report be filed.
House Action: The report was filed.

Nominations for Emeritus Membership

Reference Committee "B"

The following nominations for election to emeritus membership at the 1992 Annual Meeting have been received from the component societies. Conforming to the provisions of the Bylaws, Chapter I—Membership Section 1—Composition (d), all nominees have been members in good standing of a component society and who by reason of age or infirmity have retired from the active practice of medicine, or members of this Society who have been disabled by reason of military service.

Atlantic County

James C. Hitchner, MD, Somers Point; age 75
Daniel Wilner, MD, Northfield; age 80

Bergen County

Antonio B. Abad, MD, Paramus; age 66
Christopher Babigian, MD, Saddle River; age 71
Vincent J. Bagli, MD, Franklin Lakes; age 67
Lawrence E. Batlan, MD, Rutherford; age 68
Dean F. Davies, MD, Demarest; age 75
Peter J. Dulligan, Jr, MD, Teaneck; age 77
James Fox, MD, Teaneck; age 68
Gerald R. Frolow, MD, Bergenfield; age 67
Mary C. Googe, MD, Allendale; age 66
Samuel N. Lipsett, MD, Singer Island, FL, (formerly Paramus); age 82
Peter F. Madonia, MD, Oradell, age 66
Kenneth A. Morrissey, MD, Oradell; age 68
Peter H. Shershin, MD, Upper Saddle River; age 70
Peter D. Westerhoff, Jr, MD, Montville; age 66

Burlington County

Arthur C. Dietrick, MD, Mount Holly; age 65
Orest M. Pawluk, MD, Moorestown; age 68
Abraham J. Zagerman, MD, Mount Laurel; age 65

Camden County

Henry C. Stofman, MD, Brigantine; age 67

Cumberland County

Elmer N. Mattioli, MD, Vineland; age 66

Essex County

Robert L. Baeder, MD, Lakehurst; age 73
Franco Compagnone, MD, Essex Fells; age 67
Arnold Feldman, MD, Maplewood, age 68
Irwin J. Friedfeld, MD, Newark; age 70
Kamill Gal, MD, Convent Station; age 66
John J. Hudock, MD, Short Hills; age 68
Nicholas M. Kelemen, MD, Goleta, CA, (formerly East Newark); age 83
Leonard W. Leeds, MD, Cranbury; age 79
Joseph F. Lutz, MD, Morristown; age 67
Albert B. Sarewitz, MD, South Orange; age 69
Ronald G. Sonzogni, MD, Upper Montclair; age 63
William E. Wagner, Jr, MD, Basking Ridge; age 67
Carolyn W. Watson, MD, Glen Ridge; age 68

Hunterdon County

Frederick P. Woodruff, MD, Flemington; age 67

Mercer County

Thomas J. Dougherty, MD, Morrisville, PA; age 65
Gavin Y. Hildick-Smith, MD, New Brunswick; age 72
Howard E. Topley, MD, Titusville; age 69

Middlesex County

Lester H. Berkow, MD, Boca Raton, FL, (formerly Perth Amboy); age 57
Stanley Bresticker, MD, Somerset; age 66
Salvatore Bucolo, MD, Perth Amboy; age 67
Stephen Z. Grosz, MD, New Brunswick; age 62
Harold B. Fein, MD, East Brunswick; age 68
Vincent A. Galdi, MD, Somerset; age 68
John J. Kangos, MD, Metuchen; age 69
Richard G. Kirchner, MD, New Brunswick; age 69
John A. Smith, MD, South River; age 86
Charlotte Weiss, MD, Highland Park; age 65

Monmouth County

Clifford B. Blasi, MD, Sea Girt; age 70
Francis J. Cardiello, MD, Avon-by-the- Sea; age 68
John F. Heffernan, MD, Seaford, DE, (formerly Little Silver); age 64
Howard A. Jewell, MD, Ocean; age 64
Mary P. Mc Govern, MD, Jamesburg; age 66
Urie A. Parkhill, MD, Spring Lake: age 70
Morris Reby, MD, Elberon; age 70
Edward G. Waters, Jr, MD, Little Silver; age 64
George T. Whittle, MD, Tinton Falls; age 65

Morris County

Richard F. Hnat, MD, Key West, FL, (formerly Morristown); age 60
Nelson H. Schimmel, MD, Salem, SC, (formerly Essex Fells); age 67

Ocean County

Robert L. Miller, MD, Lakewood; age 72
Donald Pyle, MD, Point Pleasant; age 69

Passaic County

David G. Abed, MD, Oakland; age 65
Jane A. Colfax, MD, Wayne; age 69
Leo Feld, MD, Clifton; age 77
Sidney B. Shane, MD, Wayne; age 65
James R. Toombs, MD, Hawthorne; age 71
Eugene L. Wild, MD, Paterson; age 71

Somerset County

Chi Hao Edwin Lee, MD, Bridgewater; age 68
William R. Simonds, MD, Pluckemin; age 72
Arthur D. Wilson, MD, Bridgewater; age 70

Union County

Radford Brokaw, MD, Edison; age 68
Anthony J. Bruno, MD, Incline Village, NV, (formerly Elizabeth); age 71
Roy T. Forsberg, MD, Pinehurst, NC, (formerly Roselle); age 71
Warren H. Knauer, MD, Roselle; age 71
Arthur Perell, MD, Summit; age 67
Herbert E. Poch, MD, Elizabeth; age 65
Elbert H. Pogue, MD, Elizabeth; age 76
Maximillian Schoss, MD, Elizabeth; age 66
Robert R. White, III, MD, Summit; age 66
Harold S. Yood, MD, Plainfield; age 72 □

The Reference Committee recommended that the nominations be approved.

House Action: The nominations were approved.

Supplemental Report #1

Nominations for Emeritus Membership

Reference Committee "B"

Additional nominations for election to emeritus membership have been received by the Committee:

Bergen County

Harry N. Brandeis, MD, RiverVale; age 40
William J. Burokus, MD, Honesdale, PA, (formerly Paramus); age 77

Hudson County

Samuel Cohen, MD, Bayonne; age 87
G. Jerry Falcone, MD, Jersey City; age 68
Roy A. Morrow, MD, Jersey City; age 71
Francis E. Rieman, MD, Highlands; age 68
Matthew L. Schimenti, MD, Jersey City; age 79
Harry M. Schneider, MD, Jersey City; age 80

Morris County

Elizabeth Coultas, MD, Morristown; age 70

Passaic County

Theodore Louis Zahne, MD, Clifton; age 65

Union County

Meridiano M. Faxas, MD, Elizabeth; age 65
Doris D. Morales, MD, Elizabeth; age 65
Jacques Wallach, MD, Cranford; age 65 □

The Reference Committee recommended that the nominations be approved.

House Action: The nominations were approved.

Supplemental Report #2

Nominations for Emeritus Membership

(Reference Committee "B")

Additional nominations for election to emeritus membership of the Medical Society of New Jersey have been received:

Cumberland County

Anthony E. Chmelewski, MD, Ocean City; age 70

Middlesex County

Samuel F. D'Ambola, MD, Atlantic Highlands; age 70
Maria Martinez, MD, Fords; age 64 □

The Reference Committee recommended that the nominations be approved.

House Action: The nominations were approved.

Supplemental Report #3:

Nominations for Emeritus Membership

Reference Committee "B"

Additional nominations for election to emeritus membership of the Medical Society of New Jersey have been received:

Bergen County

J. Richard Mazzara, MD, Teaneck; age 68

Essex County

Carl J. Schopfer, MD, Bloomfield; age 69

Morris County

Allyn P. Kidwell, MD, Ridgewood; age 66

Ocean County

Theresa L. Siebert, MD, Manasquan; age 66
Sailendra K. Sinha, MD, Toms River; age 67 □

The Reference Committee recommended that the nominations be approved.

House Action: The nominations were approved.

Resolutions

Resolution #2

Introduced by: Bergen County Medical Society
Subject: Revision of Medical Waste Laws
Referred to: Reference Committee "B"

Whereas, the current medical waste registration, tracking, and disposal system is unduly burdensome and expensive for physicians, dentists, and other professional practitioners; and

Whereas, physicians are fully cognizant of the necessity to protect the environment and that alternate, secure channels of regulated waste disposal do exist; and

Whereas, federal and state environmental studies have concluded that materials emanating from practitioners' offices are not significant and do not present a recognizable public or environmental health hazard; now therefore be it

Resolved, that the Medical Society of New Jersey (MSNJ) seek an amendment to state and federal medical waste registration, tracking, and disposal laws exempting practitioners producing less than 200 pounds of medical waste per year; and be it further

Resolved, that MSNJ urge the American Medical Association (AMA) to seek a similar exemption under federal laws for all practitioners who generate less than 200 pounds of medical waste per year.

The Reference Committee agreed that the emphasis of medical waste regulation should be on content rather than on weight. The medical profession needs to be perceived as a guardian of the public's health.

The Reference Committee recommended that Resolution #2 be rejected.

House Action: Resolution #2 was adopted.

Resolution #9

Introduced by: Middlesex County Medical Society
Subject: AMA National Physician Credential Verification Service
Referred to: Reference Committee "B"

Whereas, society looks to the state and to the medical profession as never before to assure that licensed medical practitioners, in fact, are qualified to carry out their obligations; and

Whereas, licensing authorities have sought to collect data pertaining to the qualifications of the individual applicants from a variety of sources—a process that entails an enormous expenditure of time and considerable expense; and

Whereas, the National Practitioner Data Bank was established to attempt to remedy purported inadequacies in the obtaining of needed "negative" information about potential applicants; and

Whereas, the American Medical Association (AMA) National Physician Credential Verification Service has been established, and currently is operational, to provide single-source access to essential background information needed by licensing authorities, hospital credentialling committees, state medical societies, and other professional organizations; and

Whereas, at least 15 state medical licensing authorities accept this source and 10 more authorities are contemplating doing so; now therefore be it

Resolved, that the Medical Society of New Jersey (MSNJ) endorse the AMA National Physician Credential Verification Service; and be it further

Resolved, that MSNJ encourage the New Jersey State Board of Medical Examiners, hospital credentialling committees, medical societies, and professional associations to subscribe to and utilize the AMA National Physician Credential Verification Service.

The Reference Committee applauded the AMA's verification service, and expressed concern at its underutilization in New Jersey.

The Reference Committee recommended that Resolution #9 be adopted.

House Action: Resolution #9 was adopted.

Resolution #10

Introduced by: Middlesex County Medical Society
Subject: Location of Annual Meeting
Referred to: Reference Committee "B"

Whereas, the Annual Meeting of the Medical Society of New Jersey (MSNJ) currently is being held in Atlantic City; and

Whereas, the membership of MSNJ resides in all areas of the state; and

Whereas, facilities now exist in all sections of the state that can handle the Annual Meeting; and

Whereas, rotating the regions for the Annual Meeting is an equitable method for sharing the travel burden; now therefore be it

~~**Resolved,** that the Annual Meeting location of MSNJ be rotated between the northern, central, and southern regions of the state, in equal distribution.~~

Resolved, that the Annual Meeting location of MSNJ be rotated among various regions of this state where feasible.

The Reference Committee recognized that varied locations for the Annual Meeting should promote increased attendance; however, it was felt that meeting sites that fulfill all MSNJ's requirements are limited.

The Reference Committee recommended that Resolution #10 be adopted as amended.

House Action: Resolution #10 was adopted as amended by the Reference Committee.

Resolution #11

Introduced by: Middlesex County Medical Society
Subject: Packaging of Pharmaceutical Samples
Referred to: Reference Committee "B"

Whereas, physicians and all citizens are concerned about the amount of unrecyclable waste being generated in this country, and its impact on the earth and its environment; and

Whereas, the pharmaceutical and health care fields have been responsive to health care professionals with regard to their concerns; now therefore be it

Resolved, that the Medical Society of New Jersey (MSNJ) encourage the pharmaceutical industry, as well as all health care companies, to be environmentally considerate when designing packaging for their products.

The Reference Committee recommended that Resolution #11 be adopted.

House Action: Resolution #11 was adopted.

Resolution #15

Introduced by: Passaic County Medical Society
Subject: New Jersey Pays Medicare Difference
Referred to: Reference Committee "B"

Whereas, the United States Court of Appeals for the Second Circuit has ruled that Medicaid in the state of New York must pick up the difference between what Medicare allows and what it pays out in reimbursements for the care of the elderly poor who are covered by Medicaid; now therefore be it

Resolved, that the Medical Society of New Jersey (MSNJ) take appropriate ~~legal~~ action, with or without the participation of other organizations, to require Medicaid in the state of New Jersey to cover the difference between what Medicare allows and what it actually pays—including the deductible and coinsurance.

Fiscal Note: Unbudgeted expense; other methods are available. If litigated, the cost would be $100,000.

It was the consensus of the Reference Committee that measures other than legal should be pursued to resolve this dilemma.

The Reference Committee recommended that the word "legal" be deleted.

The Reference Committee recommended that Resolution #15 be adopted as amended.

House Action: Resolution #15 was adopted as amended by the Reference Committee.

Resolution #17

Introduced by: Michael Baruch, MD, Delegate, Passaic County
Subject: Fees for the Disposal of Medical Waste
Referred to: Reference Committee "B"

Whereas, the New Jersey State Department of Environmental Protection assesses a separate registration fee for every practice location; and

Whereas, many physicians have more than one office and must pay a separate registration fee for each location; now therefore be it

~~**Resolved,** that the Medical Society of New Jersey (MSNJ) take appropriate action so that the medical waste registration fee is assessed to the physician rather than individual office locations.~~

Resolved, that MSNJ take appropriate action so that the medical waste registration fee is assessed to the practice rather than the individual office locations.

Although the Reference Committee agreed with the spirit of Resolution #17, the members felt it did not adequately address the problem.

The Reference Committee recommended that Resolution #17 be rejected.

House Action: Resolution #17 was adopted as amended by the House of Delegates.

Resolution #19

Introduced by: Bergen County Medical Society
Subject: Request for MSNJ Contribution to Doctor Lois J. Copeland's Legal Action Against the Federal Government
Referred to: Reference Committee "B"

Whereas, there has been little, if any, progress in the efforts to forestall the Health Care Financing Administration (HCFA) and Pennsylvania Blue Shield (PBS) interference in the delivery of quality medical care to our patients; and

Whereas, attempts to improve this situation through education and conferences with our state legislators and congressional representatives have proved fruitless; and

Whereas, doctors are becoming increasingly frustrated by this downward spiral for the practice of quality medicine; and

Whereas, Doctor Lois J. Copeland's efforts to address our grievances in federal court seem to be the only avenue for a successful resolution to this current situation; now therefore be it

~~**Resolved,** that the Board of Trustees expend a specific maximum available contribution to assist Doctor Lois J. Copeland in her legal action against the federal government regarding the right to contract outside the Medicare program.~~

Fiscal Note: No budget available. Case could cost as little as $10,000 if government prevails earlier. If taken to the Court of Appeals, fiscal note is $200,000.

~~*Resolved, that the Board of Trustees consider expending a reasonable amount as a donation to assist Doctor Lois J. Copeland in her legal action against the federal government regarding the right to contract outside the Medicare program. Physicians are encouraged to make voluntary contributions on an individual basis; and be it further*~~

~~*Resolved, that the New Jersey Delegation submit this issue to the AMA at the 1992 Annual Meeting.*~~

Substitute Resolution

Resolved, that the Board of Trustees consider expending a reasonable amount as a donation to assist Doctor Lois J. Copeland and her Medicare patients in their legal action against the federal government regarding the right to contract outside the Medicare program; and be it further

Resolved, that the Medical Society of New Jersey (MSNJ) actively seek tax-deductible donations to the legal fund regarding the right to contract outside the Medicare program from the membership, from other health care professionals, and from the general public; and be it further

Resolved, that the New Jersey delegation submit this issue to the AMA at the 1992 Annual Meeting.

The Reference Committee, while sympathetic to Doctor Copeland's aims, felt that budgetary constraints limit consideration of monetary support by MSNJ.

The Reference Committee recommended that Resolution #19 be adopted as amended (italics indicate amendment).

House Action: Substitute Resolution #19 was adopted by the House of Delegates.

Resolution #20

Introduced by: Bergen County Medical Society
Subject: Request to MSNJ to Alternate Committee Meeting Dates and Places
Referred to: Reference Committee "B"

Whereas, many physicians who would like to be active on Medical Society of New Jersey (MSNJ) committees live or practice more than one hour from Lawrenceville; and

Whereas, Wednesday is no longer "doctor's day off"; and

Whereas, holding all committee meetings in Lawrenceville unfairly allows physicians who live in the Lawrenceville area to have a greater voice in MSNJ policy; now therefore be it

Resolved, that the Board of Trustees consider alternating committee meeting dates and places to accommodate all committee members.

Fiscal Note: The estimated expenditure for additional staff, meeting room rentals, administrative expenses, transportation, and insurance costs is $180,000.

The Reference Committee noted that transportation of staff, meeting room rental, administrative expenses, and insurance costs would make implementation of this proposal expensive and impractical. As an alternative proposal, it was suggested that the Board of Trustees investigate the feasibility of video-teleconferencing in emergency situations, not on a regular basis. The Reference Committee emphasized the value of face-to-face contact. They pointed out the advantages to the present central location of MSNJ headquarters.

The Reference Committee recommended that Resolution #20 be rejected.

House Action: The House of Delegates referred Resolution #20 to the Board of Trustees.

Resolution #21

Introduced by: Bergen County Medical Society
Subject: HCFA Forms
Referred to: Reference Committee "B"

Whereas, the federal government has selectively increased the administrative costs of treating Medicare patients; and

Whereas, the Health Care Financing Administration (HCFA) and Pennsylvania Blue Shield (PBS) both require new Medicare forms that are costly to purchase and continue to increase the administrative cost of medicine at a time when reimbursements are decreasing; and

Whereas, the technology that these new, more costly forms are designed to utilize currently is not being used, nor will it be in the foreseeable future; and

Whereas, the federal government has mandated that physicians be required to complete these forms for the patient without reimbursement for the administrative cost, or for the raw cost of the forms; now therefore be it

Resolved, that the Board of Trustees be instructed to initiate ~~legal~~ *legislative* action against HCFA, *in order to obtain* injunctive ~~and PBS, seeking in-~~ ~~junctive~~ and permanent relief from this onerous and expensive task of billing on HCFA forms without the ability to pass all the costs to the government or to the patient.

Fiscal Note: Unbudgeted expense. Litigation through Circuit Court of Appeals is $200,000.

The Reference Committee agreed that legislative relief would accomplish the objective without the expense of legal action called for by Resolution #21. The Committee further agreed that PBS should be excluded from Resolution #21 because it is not involved in the problem.

The Reference Committee recommended that Resolution #21 be adopted as amended (italics indicate amendment).

House Action: Resolution #21 was adopted as amended by the Reference Committee.

Resolution #23

Introduced by: Bergen County Medical Society
Subject: Right of Physician To Pass Certain Federal and State Mandated Administrative Costs on to the "Consumer"
Referred to: Reference Committee "B"

Whereas, the state of New Jersey has mandated additional costs for the continued practice of medicine in the form of licensing costs for medical waste disposal; and

Whereas, additional costs for continued and regular disposal of these medical wastes also are mandated through restrictive and regulated industries that are quite expensive; and

Whereas, no other industry is specifically denied the right to pass mandated administrative costs on to the ultimate consumer; and

Whereas, Pennsylvania Blue Shield (PBS) specifically stated that medical waste disposal is a normal cost of practice and should be included in the reimbursement rate for a regular office visit; and

Whereas, there is no mention in any federal legislation that specifically prohibits the passing on to patients for new, state-mandated costs for the practice of medicine; and

Whereas, it is only the Health Care Financing Administration (HCFA) and PBS interpretation that prevents physicians from billing for a medical waste disposal fee to reimburse them for state-mandated costs to practice medicine; now therefore be it

Resolved, that the Board of Trustees be instructed to initiate a lawsuit against HCFA and PBS, and any other federal, state, or local agency that interferes with the physician passing on mandated costs to the ultimate consumer, seeking a permanent injunction to prevent such agencies from enacting penalties or in any other way interfering with said charges.

Fiscal Note: Unbudgeted expense. Estimated litigation cost through the Circuit Court of Appeals is $200,000.

Resolved, *that the Board of Trustees be instructed to seek corrective legislation, addressed to HCFA, Congress, and any other federal, state, or local agency that interferes with the physician passing on mandated costs to the ultimate consumer, seeking permanent relief to prevent such agencies from enacting penalties or in any other way interfering with said charges.*

The Reference Committee believed that a legislative approach would be more effective and economical than litigation. The Committee further agreed to exclude PBS because it is not involved.

The Reference Committee recommended that a substitute resolution be adopted.

House Action: The House of Delegates referred Resolution #23 and the changes (noted in italics) proposed by the Reference Committee to the Board of Trustees.

Resolution #29

Introduced by: Hudson County Medical Society
Subject: AIDS
Referred to: Reference Committee "B"

Whereas, New Jersey has one of the highest rates of AIDS infection in the nation; and

Whereas, New Jersey has one of the highest number of infants born with the infection; and

Whereas, couples are required to be tested for syphilis to obtain a marriage license; and

Whereas, legislation (A-1027) has been introduced into the Assembly Health and Human Services Committee; now therefore be it

Resolved, that the Medical Society of New Jersey (MSNJ) endorse mandatory AIDS testing as a requirement for a marriage license in New Jersey and encourage the state government to provide the testing free or at a reasonable cost.

The Reference Committee acknowledged the positive concept of Resolution #29, but felt that it does not adequately address the problem. The preponderence of HIV-infected infants are born to drug users and unwed mothers; therefore, mandatory AIDS testing as a requirement for a marriage license in New Jersey would fail to produce the intended result.

The Reference Committee recommended that Resolution #29 be referred to the Special Committee on AIDS for further study.

House Action: Resolution #29 was referred to the Special Committee on AIDS for further study.

Council on Medical Services

Richard H. Sharrett, MD
Chairman

Reference Committee "C"

Redefining structure of the Council on Medical Services. The Board of Trustees requested an opinion from the Council regarding the following recommendation: "That the Board of Trustees consider redefining the structure of the Council on Medical Services."

The Council submitted the following recommendation to the Board of Trustees: "That the function of the Council on Medical Services shall be to address and to evaluate socioeconomic, scientific, utilization, quality care, and any other issues related to medical services in the state of New Jersey."

Also, the Council submitted the following recommendation: "That where possible, issues relating to the Council on Medical Services should be referred to the Council on Medical Services and ad hoc or subcommittees should be formed under the auspices of the Council, rather than the formation of ad hoc committees at any other level."

Also, "That members of the Medical Society of New Jersey (MSNJ) who are not members of the Council should be included as consultants, at the discretion of the chairman."

Request from Alvin S. Schwartz, MD, to discuss discrepancy in fees paid by Prudential. The Council fully reviewed the request from Dr. Schwartz and submitted the following recommendation to the Board of Trustees: "That the Board of Trustees of MSNJ write to Raymond C. Allen, Jr, The Prudential Insurance Company of America, requesting certification that the review of these cases was conducted by an orthopedist, and appropriate documentation."

The Council also submitted the following, "That a letter be written to the Department of Insurance and the State Board of Medical Examiners requesting their standards of professional review regarding fee review by a physician of the same specialty."

This recommendation was approved by the Board of Trustees.

Medicare mandatory assignment/Senior Courtesy Program. The topic of Medicare mandatory assignment and the Senior Courtesy Program was referred to the Council by the Board of Trustees. The Council is gathering information and will make its report back to the Board when completed.

Medicare alternative plan for New Jersey senior citizens. This item originally was referred to the Council by the Board of Trustees. It is being thoroughly investigated by Lois Copeland, MD, and by a subcommittee appointed by the chairman. □

The Reference Committee recommended that the report be filed.
House Action: The report was filed.

Resolutions

Resolution #5

Introduced by: Essex County Medical Society
Subject: Unnecessary Insurance Regulation
Referred to: Reference Committee "C"

Whereas, managed care insurers demand compliance with extensive, intrusive, and costly quality assurance and review programs from contracting medical offices; and

Whereas, such programs threaten to alter existing medical office recordkeeping, and laboratory and physical structures; and

Whereas, national legislative and administrative mandates have forced such programs on the insurance industry; and

Whereas, these programs are duplicative and intrude on the domain of state and local regulatory bodies; and

Whereas, they are unnecessarily diluting funds that could be spent more wisely on direct health care; now therefore be it

Resolved, that the Medical Society of New Jersey (MSNJ) work with managed care insurers, and state and local regulatory bodies to remove unnecessary, burdensome, duplicative, and costly quality assurance regulations; and be it further

~~**Resolved, that MSNJ study the cost and impact of unnecessary, burdensome, duplicative quality assurance regulations on the health care dollar; and be it further**~~

Resolved, that MSNJ forward a resolution to the American Medical Association to foster removal of costly, unnecessary, burdensome, and duplicative regulations and legislation that prevent spending the health care dollar on health care.

The Reference Committee recommended that the second resolved be deleted in its entirety.

The Reference Committee recommended that Resolution #5 be adopted as amended.

House Action: Resolution #5 was adopted as amended by the Reference Committee.

Resolution #6

Introduced by: Essex County Medical Society
Subject: Closing Pediatric Beds
Referred to: Reference Committee "C"

Whereas, the New Jersey State Department of Health (NJDOH) State Health Plan calls for the closing of all pediatric inpatient beds in many hospitals throughout the state under a new regionalized plan; and

Whereas, at the February 3, 1992, public hearing on this matter, representatives from these hospitals and the communities they serve disclosed evidence of undue hardships if these pediatric beds were unavailable; and

Whereas, the state's decision to close the beds was made on the arbitrary considerations of occupancy rate and total admissions without any regard to the hardship left on the community; now therefore be it

Resolved, that the Medical Society of New Jersey (MSNJ) petition the commissioner of health and the governor to reconsider the hardships on individual communities that would result from the closing of their pediatric beds; and be it further

Resolved, that NJDOH be requested to work closely with MSNJ and the New Jersey Hospital Association on this matter; and be it further

Resolved, that NJDOH be requested to include MSNJ in decisions regarding all other aspects of the State Health Plan involving interaction between physicians and their patients.

The Reference Committee recommended that Resolution #6 be adopted.

House Action: Resolution #6 was adopted.

Resolution #14

Introduced by: Passaic County Medical Society
Subject: Medicare Reimbursement of New Physicians
Referred to: Reference Committee "C"

Whereas, physicians completing training programs are burdened by heavy debts; and

Whereas, these physicians incur further debt if they chose to establish a practice; and

Whereas, federal and state laws prohibit discrimination on the basis of age; and

Whereas, it is unconscionable to reimburse new physicians at 80 percent of the amount reimbursed to already practicing physicians in the first year of practice, 85 percent in the second year, 90 percent in the third year, and 95 percent in the fourth year; now therefore be it

Resolved, that the Medical Society of New Jersey (MSNJ) petition the American Medical Association (AMA) to campaign to ~~remove~~ *repeal* the onerous congressional act that reduces reimbursement under Medicare for physicians during their first four years in practice.

The Reference Committee recommended that the word "remove" be deleted and the word "repeal" be substituted.

The Reference Committee recommended that Resolution #14 be adopted as amended.

House Action: Resolution #14 was adopted as amended by the Reference Committee (italics indicate amendment).

Resolution #16

Introduced by: Michael Baruch, MD, Delegate, Passaic County
Subject: Children and Pre-existing Conditions
Referred to: Reference Committee "C"

Whereas, children who are born with congenital anomalies may require many procedures to treat these problems; and

Whereas, insurance companies have restrictive policies regarding prior existing medical conditions; now therefore be it

Resolved, that the Medical Society of New Jersey (MSNJ) take appropriate action with the New Jersey state commissioner of insurance to assure a governmental policy similar to those legislated in California that abolish restrictions on children's health coverage due to prior existing conditions.

During the discussion of Resolution #16, the author indicated his intention to include adults as well as children. The proposed changes require legislation, not regulation, from the Department of Insurance. A number of economic issues also were discussed, i.e. the uninsured and the underinsured, the cost of premiums to small group insurers.

The Reference Committee recommended that Resolution #16 be referred to the Board of Trustees for further study and appropriate referral.

House Action: Resolution #16 was referred to the Board of Trustees for further study and appropriate referral.

Resolution #30

Introduced by: Hudson County Medical Society
Subject: Assisting Surgeons
Referred to: Reference Committee "C"

Whereas, recent federal legislation and regulations have dramatically and excessively reduced Medicare reimbursements for surgical services by as much as 50 percent in some cases; and

Whereas, the assistant at surgery, who previously had been reimbursed at a fee traditionally defined as a percentage of 20 to 25 percent of the surgeon's fee, is, thus, automatically assuming an excessive reduction in his reimbursement; and

Whereas, recent legislation (OBRA 1990) mandated a further reduction for the surgical assistant to only 16 percent of the surgeon's already reduced approved amount, thus representing an unfair and perhaps unintended (or illegal) sequence of reductions (a double hit); and

Whereas, the consequent financial strains may limit the availability of an assistant surgeon and, thus, may affect health care delivery to Medicare patients; now therefore be it

Resolved, that the Medical Society of New Jersey (MSNJ) and the American Medical Association (AMA) petition Congress to immediately restore for reimbusement under Medicare the fees of assistant surgeons to the more equitable 25 percent of the surgeon's fee.

The AMA presently is working on a policy to re-establish adequate reimbursement for assisting surgeons. The Reference Committee believed that MSNJ should support AMA efforts and delay action pending the receipt and review of AMA policy.

The Reference Committee recommended that Resolution #30 be referred to the Board of Trustees.

House Action: Resolution #30 was referred to the Board of Trustees.

Resolution #32

Introduced by: Hudson County Medical Society
Subject: Cost Containment: Whose Burden?
Referred to: Reference Committee "C"

Whereas, the federal government, through the Health Care Financing Administration (HCFA), finds it proper to limit Medicare reimbursements for physicians' services as a means of cost containment; now therefore be it

Resolved, that the Medical Society of New Jersey (MSNJ)—if it is unable to convince HCFA of the necessity for prompt restoration of previous rates of reimbursement—request that all expenses of a medical practice, e.g. personnel, rent, overhead, supplies, equipment, and insurance, be reduced by a similar percentage, and that HCFA impose "limiting charges" upon vendors of such services and products to physicians.

Although the Reference Committee expressed sympathy with the concept of Resolution #32, the Committee unanimously agreed that implementation of Resolution #32 is impractical because it would require federal control of all expenses of a medical practice, as well as extensive and controversial federal legislative enactments.

The Reference Committee recommended that Resolution #32 be rejected.

House Action: Resolution #32 was rejected.

Resolution #34

Introduced by: Hudson County Medical Society
Subject: Limiting Charges for Patients with Major Medical Insurance
Referred to: Reference Committee "C"

Whereas, Congress has attempted to limit Medicare expenditures through recent legislation; and

Whereas, Congress has attempted to protect patients from burdensome bills for medical expenses; and

Whereas, the application of limiting charges by the Health Care Financing Administration (HCFA) for medical services to patients who have third-party major medical insurance achieves neither of the two goals, does not save money for the patient nor for Medicare, but rather saves money (at the physician's expense) for the major medical carrier; now therefore be it

Resolved, that the Medical Society of New Jersey (MSNJ) promptly petition Congress and HCFA to remove the limiting charges for patients who carry third-party major medical supplemental insurance; and be it further

Resolved, that Resolution #34 be forwarded to the American Medical Association (AMA).

It was the consensus of the Reference Committee that Resolution #34 would be difficult to implement, due to the limited number of Medicare patients covered by major medical insurance.

The Reference Committee recommended that Resolution #34 be rejected.

House Action: Resolution #34 was referred to the Board of Trustees.

Resolution #41E

Introduced by: Robert J. Weierman, MD, Delegate, Essex County
Subject: Organized Medicine's Role in Health Policy
Referred to: Reference Committee "C"

Whereas, its seems inevitable that before long expenditure targets will be imposed to control rapidly rising health care costs because most health care reform proposals in Congress have expenditure targets as cost containment methods; and

Whereas, if expenditure targets are imposed by the government most semblances of physician autonomy would be lost; and

Whereas, if organized medicine were to propose expenditure targets in return for certain authorities, such as obtaining the ability to negotiate those targets and fees with the government, many aspects of physician autonomy could be maintained; now therefore be it

Resolved, that the Medical Society of New Jersey (MSNJ) adopt the following policy:

That there should be legally mandated formal physician organization involvement in all areas of health policy *development and implementation,* including *but not limited to* negotiation of reimbursement, review of the quality and appropriateness of care, review of the appropriateness of fees, and establishment of overall budgetary predictability; and be it further

Resolved, that the AMA be requested to seek authorization to negotiate on behalf of its member physicians.

The Reference Committee recommended that Resolution #41E be adopted with editorial changes (noted in italics).

House Action: Resolution #41E was adopted as amended by the Reference Committee.

Council on Public Relations

Andrew Coronato, MD
Chairman
Reference Committee "D"

Highlighting the 1991-1992 activities of the Council on Public Relations were the development and the placement of several print advertisements, most of which emphasized Medical Society of New Jersey (MSNJ) positions on Medicare reimbursement (Table).

The Medicare advertisement included an "800" telephone number; 600 telephone calls were received during one week. Callers were sent the color brochure, "Over 65? Here's a Guide to Health Issues You Should Know About." Approximately 9,000 copies of the brochure also were sent to county medical societies, and in January 1992, the brochure was reprinted. The brochure addressed the issues of mandatory assignment, rising costs, Senior Medical Courtesy, advance directives, disease prevention, and Medigap insurance.

The Senior Medical Courtesy and Medicare fees advertisements included listings of the telephone numbers of MSNJ and all county medical societies. In response, certain county societies expressed consternation at the volume of calls and the difficulty of satisfying the callers, many of whom wanted lists of all physicians who take assignment.

Advertisements placed in 17 dailies appeared in the following New Jersey newspapers: *Herald News,* Camden *Courier Post,* Newark *The Star-Ledger,* Bergen *Record,* Asbury Park *Press,* Morristown *Daily Record,* Atlantic City *Press,* Bridgewater *Courier News,* Trenton *The Times,* Gloucester *Times,* New Brunswick *Home News, Jersey Journal,* Burlington *Times,* Vineland *Daily Journal,* Newton *Jersey Herald,* Ocean County *Observer,* and Bridgewater *Evening News.*

Advertisements placed in six dailies appeared in the following New Jersey newspapers: Camden *Courier Post,* Newark *The Star-Ledger,* Bergen *Record,* Asbury Park *Press,* Atlantic City *Press,* and Trenton *The Times.*

Table. MSNJ print advertisements.

Topic	Headline of Advertisement	Where Placed	When
Medicare	"Here's Why I'm Against Mandatory Medicare Assignment"	17 dailies	9/91
Senior Medical Courtesy Program	"I'm On a Fixed Income. How Am I Supposed To Pay Those Medical Bills?"	17 dailies	10/91
Medicare fees	"Who Decides How Much Doctors Charge Medicare Patients?"	17 dailies	11/91
Health costs	"Why Are My Health Costs So High?"	17 dailies	12/91
DRG system	"He Was Only in the Hospital Four Days. How Could His Bill Be $52,000?"	6 dailies	1/92
MSNJ prestige	"My Doctor Belongs to the Medical Society of New Jersey. I Like That."	6 dailies	2/92
Senior medications	"Taking Medication? Take It to your Doctor."	6 dailies	3/92

In addition, the Medicare fees and health costs advertisements appeared as full-page advertisements in New Jersey editions of *Time* magazine.

Due to the nationwide recession, substantial billboard space throughout New Jersey recently has been empty. MSNJ's public relations agency, Paolin & Sweeney, negotiated to secure 100 postings throughout the state. The Council approved the following public health messages, which appeared on these billboards with the MSNJ name and logo: "Seatbelt On?"; "Mammograms Save Lives"; "Don't Drive Drunk"; "Fight AIDS! Get Tested"; "Pregnant? Get Medical Care"; and "Protect Your Kids with Vaccines."

Ten-second television public service announcements were developed on mammograms, AIDS, stress, blood pressure, and quitting smoking.

Also on electronic media, MSNJ supported the popular political interview and panel show, "Caucus New Jersey," with commentator Mr. Steve Adubato, on New Jersey Network and Channel 13. MSNJ also underwrote coverage of Governor Florio's 1992 State of the State and budget messages, including Republican responses. An MSNJ-supported television documentary, "One from the Heart," was aired nationally and was nominated for a regional Emmy award. All MSNJ-backed programming received generous on-air credit.

Further, the Council took steps to recognize 30-year members of MSNJ with a plaque or pin. The Council hosted the Golden Merit Award ceremony for 50-year physicians during the MSNJ Annual Meeting in Atlantic City. The Council endorsed mini-internships to improve relations with decision makers. Finally, the Council developed a detailed strategy for conferences, focusing on health care reform nationally and in New Jersey.

Several of these actions were taken in response to referrals from the Board of Trustees. The senior medications advertisement was based on Resolution #9 from the 1991 House of Delegates that MSNJ adopt a public relations program advising senior citizens to take their accumulated medications, both prescription and over the counter, to their physicians to review appropriateness, dating dosage, drug interactions, and side effects. The MSNJ prestige advertisement was intended as a positive, image-enhancing response to the Board's referral of a proposed physician "bill of rights." And, the 30-year membership recognition responds directly to a Board referral.

In the future, the Council may weigh the relative merit of placing messages in alternative media: 17 dailies; 6 dailies; and public or cable television. Council members believe that it is imperative to publicize problems with current trends in health care regulation, and to present a positive image of MSNJ and the medical profession, in order to guarantee high-quality health care and to protect all physicians in the state.

At the time of this report, the Council on Public Relations held four meetings: September 11, 1991; October 23, 1991; December 4, 1991; and January 15, 1992. □

The Reference Committee recommended that the report be filed.
House Action: The report was filed.

Council on Legislation

Bartholomew D'Ascoli, MD
Chairman
Reference Committee "D"

This report presents a summary of the status of legislative measures of the 204th Legislature. The Council's operations, together with a cumulative report of the Medical Society of New Jersey's (MSNJ) official positions on current legislation, are reflected regularly in official bulletins dispatched to state legislative keymen and to component societies, and in items published in *NEW JERSEY MEDICINE*, the journal of MSNJ.

The Council on Legislation continues to invite an official representative from each specialty society to all Council meetings. A notice announcing the date of each of the Council's meetings also is sent to all MSNJ official intermediaries with New Jersey specialty societies.

The Council urges that more representatives attend its meetings so that it may have the benefit of the timely thinking of specialty societies concerning proposed legislation affecting the specialty fields.

The Council also invites the chairman or representatives of each council and standing committee to attend the legislative meetings. Recent bylaw amendments make it possible for one Auxiliary member, one resident member, and one student member appointed by the president, to serve on the administrative councils and committees for a one-year term to be full voting members of the representative council and committees.

The following is a list of bills of the 1990 to 1991 Legislature that were reviewed after the meeting of the 1991 House of Delegates:

Senate/Assembly (Active)

S-3409—Russo—Generic Drugs. Requires pharmacists to advise patients of the availability of generic drugs even though the physician prescribed "brand" necessary. **Active Opposition,** interferes with the professional judgment of the pharmacist and the physician.

S-3491—Lipman—Nurse Practitioners. Authorizes nurses to practice medicine and to prescribe medications other than scheduled drugs for inpatients. **Active Opposition,** nurses are not qualified to make a medical diagnosis nor to prescribe therapeutic medications (Law c.377, P.L. 1991).

S-3510—Lipman—Physician Assistants. Provides registration for physician assistants through a separate licensing board; does not require on-site supervision, but does call for a filed protocol. Maintains a supervising ratio of one physician to two physician assistants. It does not provide for participation in surgery except for suturing and wound care, incision, and drainage of superficial infections and cast application for simple fractures. **Active Opposition,** registration of physician assistants neither will contribute to the quality of medical care nor decrease the cost of medical care and will create confusion in the delivery system (Law c.378, P.L. 1991).

S-3539—Lesniak—Optometrists. Authorizes optometrists to prescribe drugs. **Active Opposition,** optometrists are not medical doctors and, therefore, should not be given the mandate, via legislation, to prescribe and administer drugs. If the wrong medication is prescribed, what appears to be a simple problem could develop into a destructive process of the eye in a very short period of time. The bill is shortsighted in attempting to expand licensure by legislation rather than education and competence (Law c.385, P.L. 1991).

S-3588—Bassano—HIV Testing. The bill provides that: a health care professional who is working in a hospital on the effective date of the bill and who may be exposed to another person's blood or body fluids in the course of performing that person's duties shall undergo the HIV test no later than the 120th day

after the effective date of the bill, and shall be periodically retested, according to guidelines established by the commissioner of health; a health care professional who applies for employment at a hospital and who might be exposed to another person's blood or body fluids in the course of performing that person's duties shall be tested for HIV infection prior to commencing employment at the hospital, and shall be periodically retested, according to guidelines established by the commissioner of health; a health care professional who refuses to provide written informed consent to the HIV test shall be disqualified for employment at the hospital unless the person is exempted for good cause as determined by the commissioner; a person who is tested for HIV infection pursuant to this bill shall receive counseling before and after the testing in accordance with guidelines established by the commissioner; a hospital shall not administer an HIV test without first receiving the written informed consent of the subject of the test that is defined in the bill, or, if the subject of the test is legally incompetent, of an authorized representative of the test subject; a pregnant woman shall be routinely tested by her physician, as shall a newborn infant born in a non-hospital setting, for HIV infection, according to guidelines established by the commissioner; the New Jersey State Department of Health (NJDOH) shall provide for a voluntary and confidential contact tracing system to identify and counsel persons who are at risk of HIV transmission as a result of contact with an HIV infected individual; and all test results are subject to the provisions regarding confidentiality and disclosure of medical records contained in P.L. 1989, c.303 (C.26:5C-5 et seq.). **Active Opposition,** unduly discriminates against health care workers, is not consistent with epidemiology and communicable disease protocols, and runs counter to scientific evidence.

S-3610—Bennett—Tuberculosis. Permits a board of education to test new students for tuberculosis if there is no record of a Mantoux text. **Active Support.**

A-3947—Bush—HIV. Amends state law to protect patients who are HIV positive or with AIDS from discrimination. **Active Support** (Law c.493, P.L. 1991).

A-3948—Bush—HIV. Authorizes a physician to notify the sexual or needle-sharing partner of an HIV-positive patient and grants immunity when doing so in good faith. Requires written informed consent for HIV testing and directs NJDOH to distribute guidelines on universal precautions. Authorizes minors to consent to testing for HIV and repeals current law that requires notification that a decedent had HIV, hepatitis B, or other contagious disease. **Active Support.**

A-3949—Bush—HIV/Anatomical Gifts. Requires living organ donors to consent in writing to HIV tissue testing. **Active Support.**

A-4657—Roma—Joint and Several Liability. Eliminates joint and several liability except when defendants acted in concert. Allows attorney fees to successful litigants. **Active Support.**

A-4779—Rocco—Tanning Facilities. Requires tanning facilities to supply written warnings and also precludes minors from using tanning facilities. **Active Support.**

A-4822—Kalik—State Board of Medical Examiners. Provides that at least two of the ten physician members of the State Board of Medical Examiners be osteopathic physicians. **Active Support** (Law c.499, P.L. 1991).

A-4902—Pascrell—Acupuncture. Authorizes noncertified acupuncturists to practice in approved drug and alcohol treatment programs. **Active Opposition,** discriminates against patients with diseases of addiction and exposes them to treatment by unlicensed personnel.

A-4904—DeCroce—Organ Donation. Requires that the state driver's manual contains information on organ donation. **Active Support.**

A-4912—Impreveduto—Licensure/Burden of Proof. Raises the standard of proof in medical and podiatry disciplinary proceedings to "clear and convincing." **Active Support** (**S-2607** was substituted for **A-4912** and vetoed by the governor.)

A-4933—Vandervalk—Medical Malpractice/Damages. Places a $250,000 cap on noneconomic damages in medical malpractice cases. **Active Support.**

A-4934—Vandervalk—Medical Malpractice/Arbitration. Provides that arbitration shall be used when the amount in controversy is less than $50,000. **Active Support.**

A-5054—Doyle—Physician Courtesy Referral. Establishes a voluntary physician courtesy referral program for Medicare patients eligible for PAAD. **Active Support.**

A-5092—Mecca—Patient Confidentiality. Provides a civil penalty for publishing a patient's name without written permission. **Active Support.**

Senate/Assembly (Monitor)

S-3090—Cafiero—Emergency Services. Provides that hospitals with an accredited EMS may apply to NJDOH to develop and maintain an intermediate life support program with local squads under regulations adopted by the commissioner. **Support with Amendment** pending the following: Section 3.b. be revised to indicate in the event that direct voice communications fail, the EMT-intermediate (EMTI) should be restricted to a limited set of interventions as developed by the Mobile Intensive Care Unit (MICU) Medical Directors Committee and approved by the commissioner of health. Section 10 be revised to indicate that the State MICU Medical Directors Committee, which currently decides on therapeutic and pharmacological interventions for MICU paramedics, develop protocols to be approved by the commissioner of health. Inclusion of mandatory continuing education and periodic recertification requirements for EMTIs.

S-3140—Zane—Assault Weapons. Amends the current ban on assault weapons. **No Position.**

S-3383—Van Wagner—Smoking. Requires health insurers to provide benefits for successful completion of approved smoking cessation programs. **No Position.**

S-3642—Lesniak—Irradiated Food. Prohibits the distribution and sale of irradiated food. **No Position.**

S-3655—Codey—Medicaid. Extends Medicaid eligibility to certain children up to age 19. **No Position.**

A-3959—Felice—Organ Donations. Prohibits the sale or purchase of organs. **No Position.**

A-4001—Martin—State Psychiatric Study Commission. Creates a 13-member commission on the long-term role of state psychiatric hospitals and developmental centers. **Support with Amendment,** pending changing the composition of the commission to include professionals and psychiatrists and be more specifically representative of medicine and psychiatry.

A-4692—Catania—Elderly Abuse. Requires every person who has reasonable cause to believe an elderly or disabled person is the victim of abuse or exploitation to report that information to the commissioner of human services or his designee. **No Position.**

A-4802—Farragher—Lyme Disease. Establishes a prevention and control program within NJDOH. **No Position.**

A-4918—Duch—HIV/Physicians and Dentists. Requires HIV-positive physicians and dentists to obtain written consent from their patients before performing invasive procedures. **Action Deferred,** pending further information from the Task Force on AIDS.

A-4955—Kelly—Irradiated Foods. This bill eliminates the expiration date on a statute banning the sale of irradiated food. **No Position.**

A-5071—Impreveduto—Radiology Technology. Amends existing law to change "certification" to "licensure," establishes a special category of diagnostic mammographic radiologic technician, eliminates special categories for orthopedic and urologic technicians, and converts to an annual licensing cycle. Continuing education will be required as determined by regulation. **Active Opposition,** the bill would fail to enhance the quality of cancer screening, prevent flexibility in staffing, and duplicate the present voluntary certification criteria. In addition, the bill fails to take into account major components of quality of care in screening facilities, such as the quality of the equipment, the training of the radiologist, and the quality of the communication reports.

A-5078—Gill—Medicaid. Expands Medicaid coverage to children between 6 and 19 years of age whose family income does not exceed 100 percent of the federal poverty. **No Position** (Law c.328, P.L. 1991).

A-5099—Baker—Electromagnetic Fields. Requires the Radiation Protection Commission to adopt standards for electromagnetic fields. **No Position.**

Of the bills reported to the House from the First and Second Sessions of the 204th Legislature, the following were signed into law:

Active Opposition

S-2016—National Health Care. Provides for a nonbinding referendum concerning the enactment of a national health plan.

S-2583—Social Workers. Licenses the practice of social workers and includes the diagnosis and treatment of mental and emotional disorders and the use of psychotherapy.

S-2704—Orthotists and Prosthetists. Provides for the licensing of orthotists and prosthetists by the Division of Consumer Affairs. A nine-member advisory committee would assist the director. Two of the nine members would be physicians.

S-3251—Health Care Reform. A sweeping omnibus bill that, among other things, applies certificate of need to doctors, prohibits doctors from referring patients to a service in which they own an interest, prohibits dispensing beyond a four-day supply, and provides for a holographic override on generic prescriptions.

A-2811—Optometry. Amends the optometric act to repeal that section that prohibits optometrists from practicing medicine.

Conditional Approval

A-802—Medicaid. Provides that Medicaid coverage for mammograms shall be consistent with federal policy.

A-803—Health Insurance. Provides that health insurers must pay for mammograms. It does not apply to routine screening.

Approved

S-1211—Advance Directives for Health Care. Establishes procedures by which patients may execute advance directives for their care if they became incapable of making their own treatment decisions.

S-3063—Immunity. Provides that practitioners treating patients for certain conditions who become aware of the patient being a danger to a known third party must notify the third party or the police of that danger. Immunity is provided for such notification.

Disapproved with Active Opposition if the Bill Moves

S-2546—Contact Lens Dispensing. Provides for the regulation and certification of contact lens dispensers by the Board of Ophthalmic Dispensers and Technicians.

Disapproved

S-1270—Laboratory Director's Licensing. Adds "diagnostic laboratory immunology" to the list of specialty licenses.

S-3053—Blood Transfusion. This bill establishes the "Blood Safety Act of 1990." The bill requires that if a blood transfusion is likely to be necessary during surgery, a physician or surgeon must inform his patient of blood transfusion options, that is autologous, designated, and homologous blood transfusions. The physician or surgeon then would note on the patient's medical record that all blood transfusion options have been explained to the patient prior to surgery.

A-4223—Lyme Disease. Creates a nine-member governor's advisory council. One of the governor's two appointments must be a physician.

No Action

S-317—Burn Registry and Reporting. Requires physicians treating a person with burns over 5 percent of the body to report the same to state or local police. Establishes a central burn registry in the Department of Community Affairs.

A-948—Rights of Psychiatric Patients. Guarantees rights of psychiatric patients in screening services and short-term care facilities.

A-4699—Smokers' Rights. Prohibits employers from taking certain actions, with respect to employees who smoke or use tobacco products.

At the close of the 1990 to 1991 legislative year, all of the bills expired except those signed into law, vetoed, or filed by the governor. □

The Reference Committee recommended that the report be filed. **House Action: The report was filed.**

Resolution #3

Introduced by: Essex County Medical Society
Subject: Tort Reform and Administrative Initiatives
Referred to: Reference Committee "D"

Whereas, there is a growing recognition of the need for tort reform to reduce the cost of medical care as a result of bills introduced by Senator Orrin G. Hatch and the Bush Administration's focus on professional liability reform; and

Whereas, the political climate in New Jersey now may be more favorable to our seeking comprehensive solutions to the persistent problems inherent in medical liability and product liability; and

Whereas, the removal of defensive medicine will be a tremendous cost-containment measure for health care; and

Whereas, many other states have developed administrative action initiatives to handle professional liability to assure injured patients of reasonable damages on compensation and arbitration type programs; and

Whereas, liability insurance in unrelated fields, such as municipalities, manufacturing, and insurance for the service industry, such as taverns, food chains, and other professions, such as accounting, continue to rise at an unaffordable rate; now therefore be it

~~**Resolved,** that the Medical Society of New Jersey (MSNJ) develop a legislative package and cooperative plan in achieving tort reform including administrative action initiatives, such as compensation and arbitration; and be it further~~

~~**Resolved,** that MSNJ form coalitions with businessmen and specialty associations interested in correcting liability inequities; and be it further~~

~~**Resolved,** that MSNJ involve knowledgeable physicians in addressing tort reform issues before appropriate senate and assembly committees.~~

Fiscal Note: Coalition activity is unbudgeted and estimated expenditure is $15,000.

Substitute Resolution

Resolved, that MSNJ and the Medical Inter-Insurance Exchange (MIIX) continue their joint efforts and consider the following areas of tort reform:

1. Limitation of noneconomic damages.
2. Shorten and make definitive the statute of limitations for adults and children.
3. That the prevailing party be awarded counsel fees and costs.
4. That the feasibility of periodic payments for future damages be considered.
5. That MSNJ and MIIX study methods of alternative dispute resolution.

The Reference Committee considered Resolution #3 and Resolution #7 jointly because of the similarity of the subject matter.

There was lengthy discussion and debate.

The Reference Committee recognized the complicated nature of this topic and its emotional sensitivity for physicians. MSNJ and MIIX are cooperating in an effort to seek tort reform. Four bills currently are in the process of introduction.

The Reference Committee recommended that a substitute resolution be adopted.

House Action: A Substitute Resolution was adopted for Resolution #3 and Resolution #7.

Resolution #4

Introduced by: Essex County Medical Society
Subject: Sale of Tobacco Products by Pharmacies
Referred to: Reference Committee "D"

Whereas, the use of tobacco products and cigarette smoking are deemed important public health menaces; and

Whereas, the sale of tobacco products by retail pharmacies would appear to be incongruous with the professional role of pharmacists as partners in health care; and

Whereas, cigarettes and other tobacco products continue to remain available for sale in many New Jersey retail pharmacies; and

Whereas, the Medical Society of New Jersey (MSNJ) has resolved to support state pharmaceutical associations in their efforts to ban the sale of tobacco products; and

Whereas, efforts to date to achieve the goal of "tobacco-free pharmacies" have been of limited effectiveness; and

Whereas, progress in tobacco control frequently requires the concerted encouragement of physicians and other health care professionals, including legislative activity; now therefore be it

~~**Resolved,** that MSNJ advocate the use of all affirmative measures to discourage the sale of tobacco products by New Jersey retail pharmacies; and be it further~~

~~**Resolved,** that MSNJ encourage, where appropriate, the passage of suitable legislation to enable this process.~~

Fiscal Note: Unbudgeted public relations expenditure is estimated to cost $20,000.

Substitute Resolution

Resolved, that MSNJ reaffirm its support of the appropriate pharmaceutical organizations in their efforts to encourage the discontinuance of the sale of tobacco products by retail pharmacies.

The Reference Committee recommended that Resolution #4 be rejected.

House Action: The House of Delegates adopted Substitute Resolution #4.

Resolution #7

Introduced by: Monmouth County Medical Society
Subject: Tort Reform
Referred to: Reference Committee "D"

Whereas, rising litigation and defensive medicine have increased the cost of health care by 30 to 40 percent; and

Whereas, the cost of health care is an immediate national concern; and

Whereas, most of society also is affected by escalating product liability claims and personal injury claims abuse; and

Whereas, liability reform is on the federal agenda by the administration and is a timely issue; and

Whereas, other states already have enacted progressive tort reforms; now therefore be it

~~**Resolved,** that the Medical Society of New Jersey (MSNJ) act in concert with the public and with the business community to actively introduce meaningful tort reform in the current Legislature; and be it further~~

~~**Resolved,** that said tort reform include:~~

~~a. Limitation of $250,000 on noneconomic damages.~~

~~b. Decreasing sliding scale regulation for attorney contingency fees.~~

~~c. Limiting the statute of limitations for minors to four years from the event.~~

~~d. The plaintiff, if he lost, would pay counsel fees and costs.~~

~~e. Mandatory offset of collateral sources.~~

~~f. Periodic payments of future awards for damages.~~

~~g. The right of a physician to enter into an enforceable agreement with the patient governing disputes and claims subject to arbitration.~~

Substitute Resolution

Resolved, that MSNJ and the Medical Inter-Insurance Exchange (MIIX) continue their joint efforts and consider the following areas of tort reform:

1. Limitation of noneconomic damages.
2. Shorten and make definitive the statute of limitations for adults and children.
3. That the prevailing party be awarded counsel fees and costs.
4. That the feasibility of periodic payments for future damages be considered.
5. That MSNJ and MIIX study methods of alternative dispute resolution.

The Reference Committee considered Resolution #7 and Resolution #3 jointly because of the similarity of the subject matter.

There was lengthy discussion and debate.

The Reference Committee recognized the complicated nature of this topic and its emotional sensitivity for physicians. MSNJ and MIIX are cooperating in an effort to seek tort reform. Four bills currently are in the process of introduction.

The Reference Committee recommended that a substitute resolution be adopted.

House Action: A Substitute Resolution was adopted for Resolution #3 and Resolution #7.

Resolution #12

Introduced by: Middlesex County Medical Society
Subject: Community Violence
Referred to: Reference Committee "D"

Whereas, we are a group of concerned citizens, and, specifically, physicians entrusted with the welfare and care of families; and

Whereas, the prevalence and acceptance of violence harms all members of our community; now therefore be it

Resolved, that the Medical Society of New Jersey (MSNJ) educate physicians in the recognition and management of domestic violence, including, but not limited to child abuse, elder abuse, spousal abuse, and sexual abuse.

The Reference Committee recommended that Resolution #12 be adopted.

House Action: Resolution #12 was adopted.

Resolution #26

Introduced by: Ocean County Medical Society
Subject: Designation on Prescription Blanks for Schedule II Medications
Referred to: Reference Committee "D"

Whereas, a great number of terminally ill patients with intractable pain experience unnecessary suffering because of a lack of effectual pain medication; and

Whereas, the proper use of medications can provide effective pain relief for cancer patients; and

Whereas, current federal and state controlled substance laws and regulations discourage practitioners from prescribing adequate doses due to perceived threats from authorities who oversee prescription of schedule II drugs; now therefore be it

Resolved, that the Medical Society of New Jersey (MSNJ), through its legislative channels, seek to amend current prescription regulatory laws to include the following:

A further designation on prescription blanks identifying the drug as a palliative treatment for incurable malignancy.

The Reference Committee was of the opinion that the action called for in Resolution #26 is not necessary and opens the door for forgery and abuse. In addition, it was noted that it is not difficult to write ongoing prescriptions for patients.

The Reference Committee recommended that Resolution #26 be rejected.

House Action: Resolution #26 was rejected.

Resolution #27

Introduced by: Ocean County Medical Society
Subject: Designation of Smoking Areas in Public Facilities
Referred to: Reference Committee "D"

Whereas, cigarette smoke is a health hazard of monumental proportion; and

Whereas, passive smoke is clearly harmful to nonsmokers; and

Whereas, only 28 percent of the general population are smokers (the nonsmoker majority is 72 percent); now therefore be it

Resolved, that the Medical Society of New Jersey (MSNJ) seek legislation to provide that restaurants and public places be smokefree and, at the proprietor's discretion, provide smoking areas in lieu of current nonsmoking areas.

The Reference Committee noted that other states have adopted the policy called for in Resolution #27.

The Reference Committee recommended that Resolution #27 be adopted.

House Action: Resolution #27 was adopted.

Resolution #28

Introduced by: Ocean County Medical Society
Subject: Prohibition of Smoking in Public
Referred to: Reference Committee "D"

Whereas, cigarette smoking is a national health hazard responsible for significant morbidity and mortality; and

Whereas, a plethora of evidence exists to support the deleterious and harmful effects of passive cigarette smoke; and

Whereas, nonsmokers are not adequately protected from these effects in public institutions and workplaces; now therefore be it

~~**Resolved,** that the Medical Society of New Jersey (MSNJ) seek legislation to prohibit smoking in public areas and workplaces to ensure the safety and health of nonsmokers.~~

Substitute Resolution

Resolved, that MSNJ encourage the government to prohibit smoking in public areas and workplaces to ensure the safety and health of nonsmokers, and that MSNJ's efforts in this regard be consistent with AMA policy calling for a smokefree society by the year 2000.

The Reference Committee recommended that a substitute resolution be adopted.

House Action: Substitute Resolution #28 was adopted.

Resolution #36

Introduced by: Hudson County Medical Society
Subject: State Health Plan
Referred to: Reference Committee "D"

Resolved, that the Medical Society of New Jersey (MSNJ) initiate a campaign to encourage legislators to enact legislation to delay implementation of phase I of the State Health Plan; and be it further

Resolved, that the Legislature be asked to sunset phase I after one year to allow for a more orderly, democratic process to be used in addressing the phase I topics.

During the discussion of Resolution #36, the Reference Committee was advised that the State Health Plan was being addressed by the Board of Trustees.

The Reference Committee recommended that Resolution #36 be referred to the Board of Trustees.

House Action: Resolution #36 was referred to the Board of Trustees.

Resolution #37

Introduced by: Hospital Medical Staff Section
Subject: Hospital Reimbursement
Referred to: Reference Committee "D"

Whereas, New Jersey presently has an all-payor rate-regulated system of reimbursement to hospitals, i.e. diagnosis-related groups (DRGs) system, even though eligible organizations are not precluded from negotiating directly with hospitals with respect to their rates; and

Whereas, it would be a more equitable and competitive system if all payors were allowed to negotiate rates with hospitals; now therefore be it

Resolved, that the Medical Society of New Jersey (MSNJ) support legislative and/or regulatory initiatives that would create a free-market model of hospital reimbursement.

The Reference Committee understood that Resolution #37 is consistent with MSNJ policy.

The Reference Committee recommended that Resolution #37 be adopted.

House Action: Resolution #37 was adopted.

Resolution #39E

Introduced by: Burlington County Medical Society
Subject: Outdated Requirements for Premedical Education
Referred to: Reference Committee "D"

Whereas, the New Jersey State Board of Medical Examiners (SBME) follows a rule written in 1915 that adheres to rigid, outdated requirements for premedical education to qualify for licensure to practice medicine in the state of New Jersey; and

Whereas, the requirements of premedical education have changed radically since 1915; and

Whereas, many physicians who are fully licensed to practice medicine in other states of the union are unable to obtain medical licensure in the state of New Jersey due to this 1915 law; and

Whereas, this rule may have been pertinent in 1915, but serves no useful purpose in 1992 while making it impossible for fully qualified international medical graduates from practicing medicine in the state of New Jersey; and

Whereas, this antiquated law has alienated a number of international medical graduates from the Medical Society of New Jersey (MSNJ) due to the Society's lack of effort to resolve this important issue; now therefore be it

Resolved, that MSNJ petition New Jersey legislators to pass a resolution nullifying the 1915 law and giving the New Jersey SBME broader authority to evaluate the adequacy of premedical and medical education of the candidates applying for licensure to practice medicine in the state of New Jersey; and be it further

Resolved, that MSNJ support legislation to give the New Jersey SBME greater authority to determine if the deficiency of premedical education has been remedied at the graduate or postgraduate education level.

Since the Board of Trustees and SBME have discussed this topic, the Reference Committee believed that efforts along these lines should continue.

The Reference Committee recommended that Resolution #39E be referred to the Board of Trustees.

House Action: Resolution #39E was referred to the Board of Trustees.

Memorial Resolution

Edward W. Luka, MD
1933-1991

Whereas, after a life of distinguished and exemplary service as a physician and a medical leader, Edward W. Luka, MD, has been called from this life; and

Whereas, in his years as a member, Doctor Luka actively participated in his county medical society; and

Whereas, in his medical practice he always exemplified the attributes of a true humanitarian and distinguished physician; and

Whereas, Doctor Luka was appointed by the governor to the New Jersey State Board of Medical Examiners and served as president of that Board; now therefore be it

Resolved, that the Medical Society of New Jersey, honoring Edward W. Luka, MD, in death as in life, records its profound grief at his passing; and be it further

Resolved, that a copy of this resolution be spread upon the minutes of this House of Delegates, and a copy, suitably prepared, be presented to his widow and family in token of heartfelt sympathy. □

Received by the House of Delegates with sorrowful concurrence.

Informational Report: Ad Hoc Committee on Membership

Charles M. Moss, MD
Chairman

Reinstatement of Members—Resolution #2 (1991). This Resolution asked that if a hiatus in dues payment to the Medical Society of New Jersey (MSNJ) of greater than 12 months from June 1 exists, there shall not be a delinquency assessment payable to MSNJ. (The Society's current policy states that there shall not be a delinquency assessment if a hiatus of greater than 24 months from June 1 exists.) Although the Resolution was not adopted by the 1991 House of Delegates, it was referred by the Board of Trustees to the Ad Hoc Committee on Membership for review.

At its meeting on Wednesday, April 15, 1992, the Board of Trustees accepted the recommendation of the Ad Hoc Committee that called for the Society's current policy on reinstatement of members to remain in effect, and that the Ad Hoc Committee on Membership continue to study the overall issue of assessment delinquency. □

Informational Report: Committee on Medical Education

Palma E. Formica, MD

The Medical Society of New Jersey (MSNJ) Committee on Medical Education has primary responsibility for accrediting continuing medical education (CME) programs based in hospitals and other organizations. Related committee efforts include participation in conducting occasional education programs for physicians statewide.

Highlighting the Committee on Medical Education's activities for 1991-1992 were the attainment of a four-year approval (the maximum term given) by the Committee on Review and Recognition of the Accreditation Council for Continuing Medical Education (ACCME) and several initiatives: exploration of a novel concept of "focused medical education"; offering individualized education opportunities for practicing physicians through hospitals; preparation of annual workshops for MSNJ accreditation surveyors of CME programs; development of guidelines on commercial support of CME programs, in light of concerns expressed by the ACCME, the American Medical Association, the Food and Drug Administration, and a U.S. Senate subcommittee; and compilation of the Committee's policy manual on accreditation.

During 1991, relations between MSNJ and the Academy of Medicine of New Jersey (AMNJ) were formally resolved through mutual representation on committees and greater interaction. This achievement reflected the Board of Trustees' adoption of a resolution specifying the following:

1. The president of MSNJ will be an ex-officio member of the Board of Trustees of AMNJ.

2. MSNJ shall designate two additional members to serve, ex-officio, as members of the Board of Trustees of AMNJ.

3. A member of the MSNJ Committee on Medical Education shall be a member of AMNJ Education Committee.

4. The executive director of AMNJ shall be a consultant to the MSNJ Committee on Education. He or his designee will give a regular report at each meeting of the Education Committee.

5. Efforts will be made to coordinate all educational activities of both organizations. This will include announcements in all relevant publications of both organizations.

A similiar series of interactions was formalized between MSNJ and the University of Medicine and Dentistry of New Jersey (UMDNJ), also through a Board of Trustees' resolution.

Collaborating closely with related organizations, including AMNJ, UMDNJ, and the Association for Hospital Medical Education, the Committee conducted a seminar for all hospital directors of medical education in the state. The Committee also held full committee meetings on July 23, 1991; August 14, 1991; November 5, 1991; and January 14, 1992.

During 1991 the Committee reviewed 21 surveys of hospital CME programs. Results were as follows: nine organizations received four years accreditation; three organizations received three years accreditation; two organizations received two years accreditation; two organizations received one year accreditation; one organization received one year provisional accreditation; and four organizations received one year probation.

In view of the explosion of medical technology, CME is critically important to physicians. The Committee seeks to strengthen the bonds between CME and the medical community during the coming year, and beyond. □

Offices Filled By Election
1992 Annual Meeting

Office	Term	Name and County
Officer		
President-Elect	1 year	Joseph N. Micale, MD, Hudson
1st Vice-President	1 year	Fred M. Palace, MD, Morris
2nd Vice-President	1 year	Louis L. Keeler, MD, Camden
Secretary	3 years	Bernard Robins, MD, Hunterdon
Treasurer	3 years	Gerald H. Rozan, MD, Passaic
Trustees		
1st District	3 years	Mark T. Olesnicky, MD, Essex
2nd District	3 years	G. Gerson Grodberg, MD, Bergen
4th District	2 years*	S. Manzoor Abidi, MD, Burlington
5th District	3 years	Churchill L. Blakey, MD, Gloucester
Judicial Councilors		
2nd District	3 years	Roland E. Johnson, MD, Sussex
5th District	3 years	Gastone A. Milano, MD, Atlantic
AMA Delegates		
	2 years	Harry M. Carnes, MD, Camden
	2 years	Ralph J. Fioretti, MD, Bergen
	2 years	Donald J. Holtzman, MD, Union
	2 years	Irving P. Ratner, MD, Burlington
	2 years	William E. Ryan, MD, Mercer
	2 years	Edward A. Schauer, MD, Monmouth
	2 years	Robert J. Weierman, MD, Essex
AMA Alternate Delegates		
	2 years	Angelo S. Agro, MD, Camden
	2 years	Joel S. Cherashore, MD, Essex
	2 years	Walter J. Kahn, MD, Monmouth
	2 years	A. Ralph Kristeller, MD, Union
	2 years	Carl Restivo, Jr, MD, Hudson
	2 years	Leticia V. DeCastro, MD, Middlesex
	1 year**	Patricia G. Klein, MD, Bergen
	1 year**	Mark T. Olesnicky, MD, Essex
Administrative Councils		
Legislation		
1st District	2 years	George J. Hill, MD, Essex
2nd District	2 years	Donald J. Cinotti, MD, Hudson
3rd District	2 years	R. Prasad Gupta, MD, Mercer
4th District	2 years	William V. Harrer, MD, Camden
Medical Services		
1st District	2 years	Robert H. Stackpole, MD, Union
2nd District	2 years	Frederic E. Wien, MD, Passaic
3rd District	2 years	Ismail Kazem, MD, Mercer
4th District	2 years	Joseph W. Sokolowski, Jr, MD, Camden
Mental Health		
1st District	2 years	Hilda B. Templeton, MD, Essex
2nd District	2 years	†Nancy L. Mueller, MD, Bergen
4th District	2 years	James P. O'Neill, MD, Monmouth
5th District	2 years	†Kelly M. Reid, MD, Atlantic
Public Health		
1st District	2 years	Anthony J. Tarasenko, MD, Union
2nd District	2 years	John P. Mudry, MD, Bergen
3rd District	2 years	Lawrence D. Frenkel, MD, Middlesex
4th District	2 years	Mary F. Campagnolo, MD, Burlington

Public Relations		
1st District	2 years	Giovanni Lima, MD, Essex
3rd District	2 years	Leticia V. DeCastro, MD, Middlesex
4th District	2 years	Aram M. Sarajian, MD, Ocean
6th Member	2 years	Paul M. DiLorenzo, MD, Monmouth
Standing Committees		
Annual Meeting	2 years	John P. Mudry, MD, Bergen
	2 years	Jeffrey M. Solomon, MD, Cumberland
Finance and Budget	2 years	Frank L. Redo, MD, JD, Salem
	2 years	Louis G. Fares, II, MD, Mercer
Medical Education	2 years	Anthony P. DeSpirito, MD, Monmouth
	2 years	Paul C. Royce, MD, Monmouth
Membership Services	1 year	Gilbert R. Sugerman, MD, Essex
	2 years	Robert L. Maggs, MD, Monmouth
	2 years	Yale C. Shulman, MD, Hudson
Publication	2 years	M. Arif Hashmi, MD, Camden
	2 years	Morris Soled, MD, Hudson

*Elected to fill the unexpired term of Louis L. Keeler, MD, who was elected second vice-president.
**Elected to fill the unexpired terms of Donald J. Holtzman, MD, and Robert J. Weierman, MD, who were elected AMA delegates.
†No candidates were nominated. These positions were vacancies that were filled by the president.

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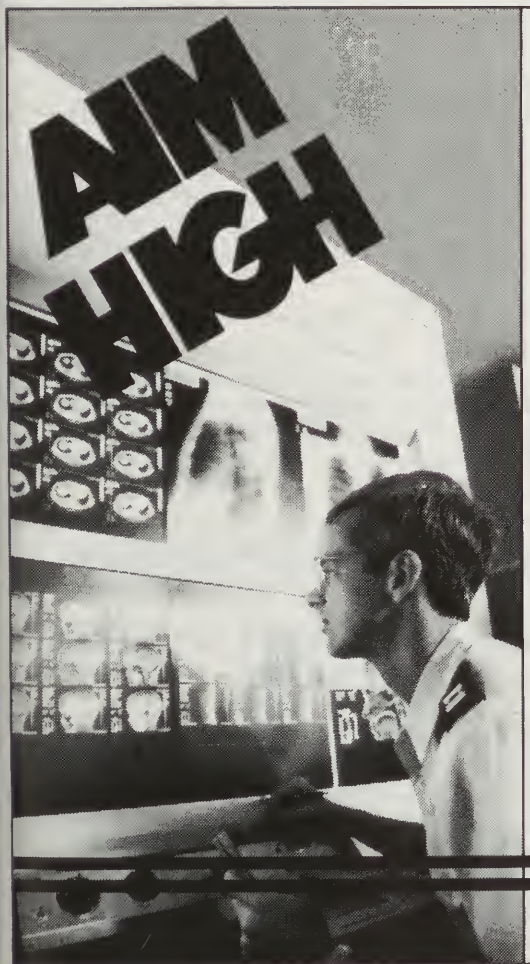
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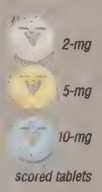
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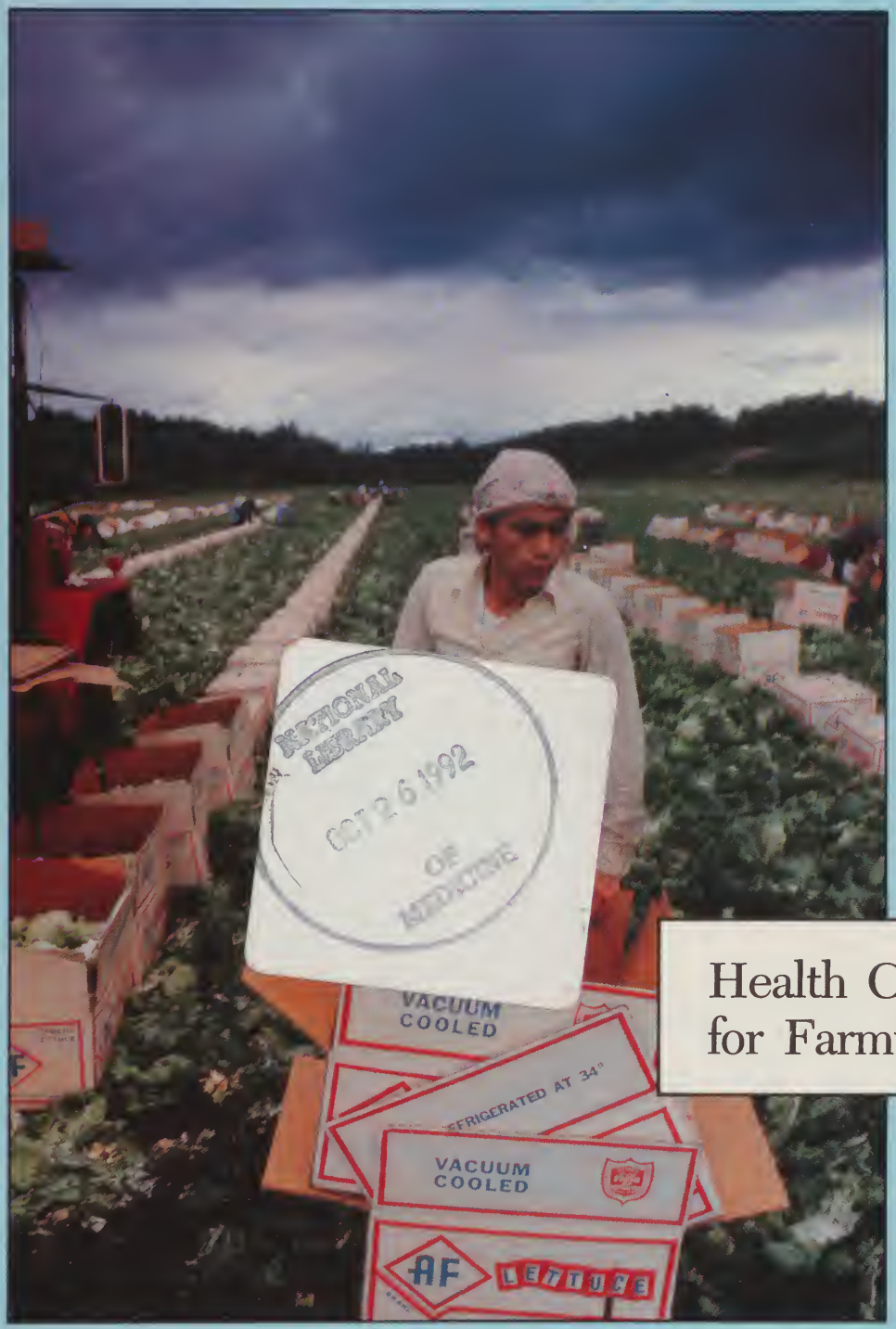
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Newswatch

BATTLE OVER STATE HEALTH PLAN RAGES...

Defying the Legislature, the Florio administration announced plans to implement the State Health Plan as a mandatory set of regulations, despite legislation that specifically makes the Plan advisory.

On June 29, 1992, the Legislature overrode the governor's veto of A-1144/S-610, which makes the Plan advisory and prohibits the adoption of regulations to implement the purposes of the Plan. Governor Florio reacted angrily, accusing the Senate and Assembly of caving in to MSNJ, the New Jersey Hospital Association, and other "special interests."

To justify its refusal to obey the law, the administration contends that the section of the law that prohibits the adoption of regulations is unconstitutional, because it violates the separation of powers and due process of law. The administration concedes that the provision making the Plan advisory does pass constitutional muster. For all practical purposes, the Plan consists of regulations; in effect, the administration is contending that the Plan can be both advisory and mandatory at the same time.

Controversy over the Plan has focused on provisions that would force the closure of six hospitals in the state and would reduce or close many pediatric services in community hospitals. However, MSNJ's primary concern is that the Plan would permit the governor's office to determine which hospitals provide which services. To illustrate, a recently proposed provision would prevent most community hospitals from performing laparoscopic gallbladder surgery.

STATE BOARD OF MEDICAL EXAMINERS' MEETING...

Sanford M. Lewis, MD, was re-elected president of the State Board of Medical Examiners (SBME); Fred M. Jacobs, MD, was re-elected vice-president.

SBME dismissed a four-page petition letter from MSNJ President William E. Ryan, MD, asking SBME to amend its new business practice rule in order to permit normal continuing medical education (CME) activities to take place. The rule's main proponents, Fred M. Jacobs, MD, and Deputy Attorney General Joan D. Gelber, implied that no change was needed because the rule did not pose any

threat to ongoing CME. The petition was requested by the MSNJ Committee on Medical Education.

SBME opposed A-1329, which would require physicians who treat Medicare beneficiaries to post their policy on balance billing. SBME supported, with reservations, two bills: A-518, requiring arbitration of claims below $50,000, was supported with the proviso that physicians be included in arbitration panels; and A-517, settling a $250,000 cap on awards for noneconomic damages, was supported with a request for clarification of a provision exempting "willful misconduct" and actual malice from protection under the cap. SBME supported S-635, which would permit psychologists to visit patients in hospitals with the permission of the attending physician; S-671, which would increase physician fees in worker's compensation cases; and A-1020, permitting minors to consent to alcoholism treatment. SBME opposed A-1027, HIV testing of applicants for marriage licenses; S-810, requiring parental consent for abortion in cases of minors; and A-1156/S-579, which would open investigative files to public scrutiny.

COPELAND VERSUS SULLIVAN--MEDICARE...

The AMA filed its amicus brief (July 15, 1992) in the Copeland case arguing that physicians and patients have the right to contract outside of the Medicare program. The case is scheduled for argument on September 14, 1992, in the federal district court in Newark before Judge Politan.

August 1992

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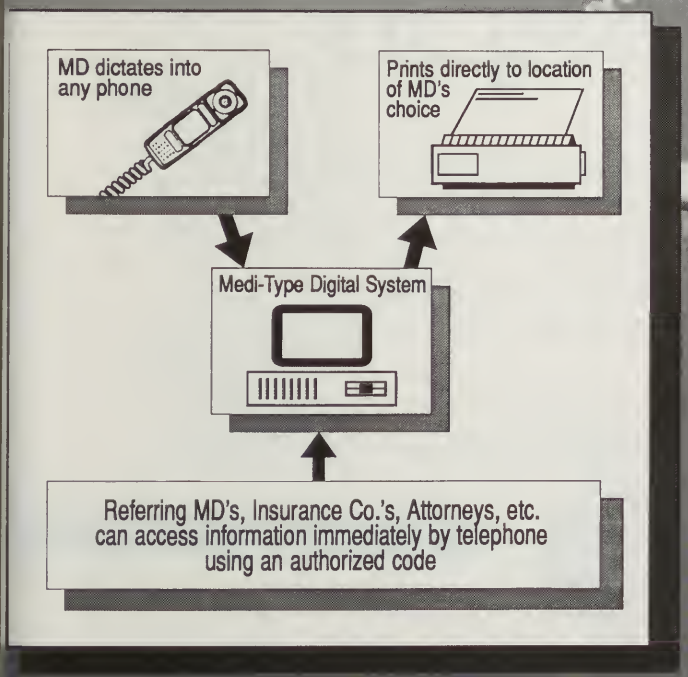
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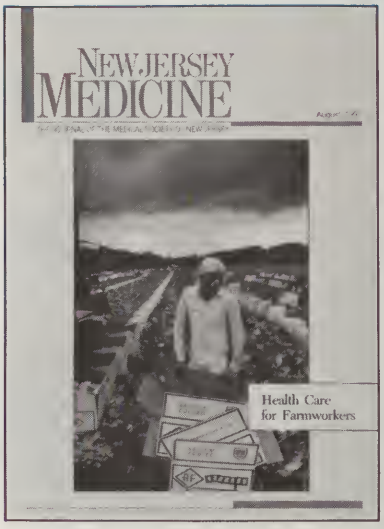
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The Cover

Migrant farmworkers comprise a severely medically underserved population in New Jersey. Our story begins on page 581. Cover photograph: BOCES Geneseo Migrant Center, Geneseo, New York.

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MSNJ NEWSLETTER

HCFA TAKES ON "HASSLE FACTOR"

The Health Care Financing Administration (HCFA) has released an advisory report making recommendations to reduce administrative burdens on physicians. The report, published by the Advisory Committee on Medicare-Physician Relationships, addressed the administrative "hassles" that physicians deal with the Medicare program.

The committee included HCFA's senior medical advisor, Nancy E. Gary, MD, and seven practicing physicians from various disciplines including family practice, internal medicine, and surgery. Secretary of Health and Human Services Louis W. Sullivan, MD, formed the panel in 1991 in response to complaints by providers that Medicare's administrative workload had become too great, adding unduly to office overhead costs and interfering with the relationship between physicians and patients.

The panel recommended the Medicare carriers set up physician advisory committees to consider physician concerns about Medicare. These committees will be composed of medical directors from the carriers and peer review organizations (PROs), presidents of state medical associations, physicians who treat Medicare patients, and Medicare beneficiaries.

The committee's report also expressed concerns about the peer review process. HCFA has developed a new strategy—the Health Care Quality Improvement Initiative—that will move the PRO program from its emphasis on individual clinical errors to helping providers improve the mainstream of medical care. Under this new initiative, PROs will shift their focus from individual case review to analysis of patterns of medical care and outcomes, using an educational rather than punitive approach.

The panel also recommended that HCFA review the language used on the explanation of Medicare benefits form to ensure that it is easily understood and presented in a neutral tone. Other recommendations included coordinating quality review of physician and hospital services, re-evaluating medical review procedures, and taking further steps to improve communications between physicians and carriers.

Copies of the report can be obtained by calling HCFA Philadelphia regional office, 1/215/596-1351.

DR. YEAGER ELECTED TO PIAA BOARD OF TRUSTEES

Harvey Paul Yeager, MD, was elected to the Board of Trustees of the Physician Insurers Association of America (PIAA) at its annual meeting in Seattle. Dr. Yeager is a board certified otolaryngologist with a private practice in West Orange. He has served seven years on the Board of Governors of the Medical Inter-Insurance Exchange, a PIAA member with headquarters in Lawrenceville, insuring over 8,000 physicians in New Jersey and Pennsylvania.

Dr. Yeager received his medical degree from Hahnemann Medical College, Philadelphia. He completed residencies in otolaryngology at Bellevue Hospital, New York, and at the Hospital of the University of Pennsylvania, Philadelphia, and a residency in general surgery at

the Hospital of the University of Pennsylvania. He is a member of the American Academy of Otolaryngology–Head and Neck Surgery, and has served on its professional liability committee since 1978. He currently is chairman of the committee.

PIAA comprises 44 physician-owned medical professional liability insurance companies that provide malpractice insurance for nearly two-thirds of practicing physicians in the United States.

CUTS FOR NJDOH

The Republican-sponsored state budget unveiled June 18, 1992, hit the New Jersey State Department of Health (NJDOH) particularly hard. NJDOH's direct services budget was slashed almost $8.5 million, or 18.3 percent, the second greatest percentage cut of the state's 19 executive departments. One reduction was for funds for outreach workers in multidrug-resistant tuberculosis, who assure that infected patients take their prescribed medications and, thus, help curtail the incipient epidemic.

In addition, NJDOH was dealt a $6.3-million, or 19.4 percent, cut in grants-in-aid, which again was the second severest percentage cut among the departments, and a $600,000 loss in income from the Casino Revenue Fund. Approximately 300 NJDOH employees, more than one-fifth of the workforce, were expected to face layoffs.

Possible explanations for the blow to NJDOH include the Republicans' resentment of the heavy-handed health care regulatory actions of Brenda Bacon, Governor Florio's top policy adviser, as well as dissatisfaction with the performance of State Health Commissioner Frances Dunston, MD, MPH, and a policy approach that redistributes health care resources from suburban to inner-city communities.

CDS RENEWALS ARE DELAYED

On June 22, 1992, the New Jersey State Department of Health announced a delay in its distribution of renewal applications for handling controlled dangerous substances. In a memorandum to the Medical Society of New Jersey, Drug Registrations Coordinator Al Ravin, RP, DC, stated that the delay would not affect physicians' prescription rights. Physicians are advised to anticipate receiving the forms soon and to retain the last copy of the completed form for their records.

SBME GUIDELINES FOR PHYSICAL EXAMINATIONS

Patient complaints of sexual misconduct by physicians are the most sensitive and difficult cases the State Board of Medical Examiners (SBME) investigates. The incidents are rarely witnessed. Allegations of sexual misconduct are particularly difficult to prove, and can lead to public humiliation for both the patient and the physician involved.

Physicians, of course, will continue to routinely perform physical examinations in the course of patient care out of medical necessity and professional responsibility. In order to prevent misunderstandings and protect physicians and their patients from allegations of sexual misconduct, SBME offers the following guidelines:

1. Maintaining patient dignity should be foremost in the physician's mind when undertaking a physical examination. The patient should be assured of adequate auditory and visual privacy, and never should be asked to disrobe in the physician's immediate presence. Examining rooms should be safe, clean, and well-

maintained, and should be equipped with appropriate furniture for the examination and treatment. Gowns, sheets, and/or other appropriate apparel should be made available to protect patient dignity and decrease embarrassment to the patient while promoting a thorough and professional examination.

2. A third party should be readily available at all times during a physical examination, and it is suggested that the third party actually be present when the physician performs an examination of the sexual and reproductive organs or rectum. It is incumbent upon the physician to inform the patient of the option to have a third party present. This precaution is essential regardless of physician/patient gender.

3. The physician should individualize his approach to physical examinations so that the patient's apprehension, fear, and embarrassment are diminished as much as possible. An explanation for the necessity of a complete physical examination, the components of that examination, and the purpose of disrobing may be necessary in order to minimize the patient's apprehension and possible misunderstanding.

4. The physician and staff should exercise the same degree of professionalism and caution when performing diagnostic procedures, i.e. electrocardiograms, electromyograms, endoscopic procedures, radiological studies, as well as surgical procedures and postsurgical followup examinations when the patient is in varying stages of consciousness.

5. The physician should be alert to suggestive or flirtatious behavior or mannerisms on the part of the patient, and should not put himself in a compromising position.

6. The physician shall not exploit the physician/patient relationship for sexual or any other purposes. Moreover, such an allegation against a physician constitutes grounds for investigation on the basis of alleged unethical behavior.

WOMEN IN MEDICINE CONFERENCES

MSNJ's Committee on Women in Medicine, fresh from a successful MSNJ convention event featuring likely gubernatorial candidate Christine Todd Whitman, is planning two conferences: September 30, 1992, a leadership conference emphasizing oral presentation skills; and March 10, 1993, a statewide conference on women's health. For details, call Karen Monsees at MSNJ, 1/609/896-1766.

MEDICAL WASTE TRANSPORTERS

A list of state-approved transporters of medical waste has been obtained. The penalties for failing to comply with state medical waste regulators are severe. To obtain a copy of the list, contact MSNJ.

SEMINARS ON PRACTICE IMPROVEMENTS

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READERS' SURVEY

Sincere thanks to all respondents of our readers' survey questionnaire, which appeared in last month's commentary. Results include the following:

The highest ratings for importance were assigned to the commentary's "Malpractice and Other Cases," Malpractice Verdicts," and "Malpractice Tips" sections, in that order. The lowest ratings were received by the proposed "Antitrust" section, the "Biomedical Ethics" section, and "Politics of Health" section. Other sections rated were "Licensure," "Health Care Financing," "Malpractice Policy Developments," "AIDS," and "Hospital Privileges," in that order.

Respondents appeared very satisfied with the depth of discussion, but gave slightly lower marks to the breadth of issues covered. We especially appreciated some of the respondents' words of encouragement.

Analysis of respondents' demographics showed that more than 90 percent had been in professional practice for at least 11, and generally more than 20, years. To overcome the graying of our readership, individual readers are asked to alert younger colleagues to *NEW JERSEY MEDICINE.*

MALPRACTICE AND OTHER CASES

Pain and capital punishment. With strong disagreement from Justices John Paul Stevens and Harry A. Blackmun, standard-bearers for the high court's moderate wing, the U.S. Supreme Court on April 21, 1992, approved capital punishment that allegedly involved the infliction of prolonged pain.

The case of Gomez versus U.S. District Court for the Northern District of California involved the pending execution by cyanide gas of convicted murderer Robert Alton Harris. The case came to the justices after the U.S. Court of Appeals for the Ninth Circuit stayed the execution, in order to hear arguments about whether the gas chamber ordeal violates the Eighth Amendment's prohibition on cruel and unusual punishment. On the state of California's application, the Supreme Court vacated the stay, and the execution by gas took place.

An unsigned majority opinion indicated intolerance for prison inmates' frequent submission of appeals and writs of habeas corpus. Stated the Court: "This claim could have been brought more than a decade ago. There is no good reason for this abusive delay, which has been compounded by last minute attempts to manipulate the judicial process."

Justice Stevens's dissent, in which Justice Blackmun joined, stressed the merits of Harris's claim instead of the timing.

Stevens contended: "In light of all that we know today about the extreme and unnecessary pain inflicted by execution by cyanide gas, and in light of the availability of more humane and less violent methods of execution, Harris's claim has merit."

Stevens cited "dozens of uncontroverted expert statements" by physicians and others about the pain of execution by gas. Subjects typically experience hypoxia while conscious for eight to ten minutes. Reactions include seizures, retching and vomiting, ballistic writhing and flailing, incontinence of stool and urine, and grimacing in pain. Added Stevens: "The barbaric use of cyanide gas in the Holocaust, the development of cyanide agents as chemical weapons, our contemporary understanding of execution by lethal gas, and the development of less cruel methods of execution all demonstrate that execution by cyanide gas is unnecessarily cruel," and thus violates the Court's century-old ban on punishments that involve "torture or a lingering death."

As to the timing, Stevens asserted that Harris's delay tactics "cannot endow the state with the authority to violate the Constitution." He noted that all 14 members of the Court of Appeals had voted to rehear the case, and stated that California could have prevented the delay by joining with other states in replacing gas with lethal injection.

MALPRACTICE VERDICTS

Cardiac catheterization and stroke. A patient in his late 40s suffered a stroke in connection with cardiac catheterization, allegedly leaving him with permanently blurred vision. The patient sued the cardiologist, contending that heparin should have been administered prophylactically to thin his blood. The physician contended that heparin had not been found efficacious in reducing the risk of stroke in patients outside high-risk groups.

To help weigh the plaintiff's

credibility, the New Jersey jury was permitted to learn that the physician was incarcerated for violating laws on controlled and dangerous substances. The jury found for the defendant.

Death by drug overdose. A patient in his late 20s presented in a New Jersey hospital emergency department with tachycardia, hypertension, and a belligerent attitude. An emergency physician examined the patient, correctly concluded that the patient had been smoking crack cocaine, prescribed medication, and waited three hours before admitting the patient to the hospital where he died.

An autopsy revealed the presence of a large quantity of cocaine in the patient's stomach. His survivors sued, claiming that the emergency department physician, an on-call internist, and house physicians should have arranged to have the stomach pumped. All but the emergency physician settled before trial. The jury found the emergency physician not negligent.

Vaginal hysterectomy. During a vaginal hysterectomy, a patient in her late 40s suffered a laceration to the ureter that was not detected until later. She sued the operating gynecologist, claiming that the complication could not have occurred in the absence of negligence and that the physician should not have closed the patient before becoming aware of the laceration.

The patient claimed that six months of pain resulted and that she underwent an extended hospitalization to repair the damage. The defendant argued that the laceration was a normal risk that occurred in the absence of negligence. He blamed the failure to observe the laceration on the clamping of the ureter during the normal course of the operation, which prevented urine from leaking. The verdict in this New Jersey case was for the defendant.

Childhood vaccination. A letter to parents from a school district explained how to permit or refuse inoculation against measles, mumps, and rubella. After receiving the letter, a mother called the principal of her 12-year-old daughter's school and the school board to protest, based on the fact that her daughter had been vaccinated nine years earlier. However, the mother failed to sign the prescribed form denying permission to administer the vaccine, and the child was given an MMR II vaccine.

Almost two years later the child was diagnosed with subacute sclerosing panencephalitis (SSPE) following the observation of physical and behavior problems. An inflammatory disease of the central nervous system, SSPE is progressively fatal. The child and her parents sued the manufacturer.

On a motion to dismiss the case, a federal district court judge in Pennsylvania agreed that federal law pre-empted claims that the manufacturer was liable for negligence in manufacturing, distributing, or labelling the vaccine. However, the court allowed that a case could be brought against the manufacturer for failing to meet its duty to warn the patient of possible effects, if the school nurse were found to be the manufacturer's learned intermediary.

The court noted that a brochure distributed with the vaccine stated that revaccination was not routinely indicated for children who, like the plaintiff child, had been vaccinated when they were older than 12 months. But, the court noted that the brochure failed to provide information about the risks of vaccination. The court postponed its decision on the motion pending additional discovery.

The case helps explain some of the nervousness about vaccination that recently led the U.S. Department of Health and Human Services to require detailed procedures and materials for warning parents at the time of vaccination. Some commentators, however, are concerned that the elaborate protections could discourage physicians from promoting, and parents from permitting, appropriate vaccinations.

MALPRACTICE POLICY DEVELOPMENTS

Pending New Jersey bills. Physicians, business, certain consumer groups, and the Florio administration have signaled interest in tort reform as a means of containing health care costs. Among bills already in the hopper: A-956, which would end joint and several liability (makes all defendants liable for the judgment) and resurrect the "British" system under which legal fees for both sides are paid by the losing party; and A-1117, which would relieve medical malpractice carriers from the Joint Underwriting Association assessment imposed on all insurers.

HMO liability. Recent *Personal Injury Newsletter* reviews of law journal articles address the emerging topic of malpractice liability of health maintenance organizations (HMOs). Michael A. Dowell writes in the University of Toledo *Law Review* that HMOs should take pains to avoid interfering with the physician-patient relationship. In addition, Mr. Dowell advises, HMO materials and contracts should acknowledge the physician's responsibility for medical decisions. Peer reviewers should be board certified and should be relevant specialists, he cautions.

An article by Jeffrey P. Phelan in *Creighton Law Review* presents diverse theories of HMO liability for malpractice.

Plaintiffs may sue HMOs for tortious interference with the

physician-patient contractual relationship, for making ultimate decisions in the guise of "captain of the ship," or for conducting the unauthorized practice of medicine, says Mr. Phelan. He sees another malpractice frontier in the supervision of residents, as plaintiffs may claim that supervising physicians failed to provide proper oversight and, thus, helped cause injuries to patients.

Structured settlements. Federal tax rules provide an opportunity for both sides in a successful malpractice suit to benefit from structured settlements. Instead of a lump sum, plaintiffs who obtain structured settlements receive payouts during the course of their lives, comparable to an annuity. The payouts are tax-free, whereas under the lump-sum approach, the award itself is not taxed but the investment income drawn from the award is taxed. Another protection is that the beneficiaries stand ahead of other creditors if the insurance firm handling the payouts becomes unable to meet its obligations.

A proposed Uniform Periodic Payments of Judgments Act, recently endorsed by the National Conference of Commissioners on Uniform State Laws, may help make structured settlements the norm nationwide. The act prescribes ways to account for inflation, calculate lawyer fees, and select an insurer. According to Edward Wilson of the Kidder Peabody Structured Settlement Group in Cleveland, the act "is going to cause a paradigm shift." Mr. Wilson was quoted in the Perspectives section of Faulkner & Gray's, *Medicine & Health*, a leading health policy newsletter.

Certificate of merit upheld. An Illinois law has been upheld requiring plaintiffs in malpractice actions to obtain a health professional's affidavit declaring that the claim has merit. The state Supreme Court ruled that the law does not violate the doctrine of separation of powers, because the judiciary retains the power to dismiss cases. Nor, said the court, does the law violate equal protection or due process, because the provision contains a rational basis.

HEALTH CARE FINANCING

Writer decries regulation. In an article published in the University of Kansas *Law Review*—under the title "Why Is Health Care Special?"—Richard A. Epstein assails government regulation of health care. The article was reviewed in *Personal Injury Newsletter*.

Mr. Epstein's title recognizes the common argument that principles of supply and demand do not apply to health care, which is "special" due to particular constraints on consumers. In the health care sector, the argument runs, consumers lack sufficient capability to assess quality, to gain rewards for avoiding high-cost services, or to make informed decisions under stressful conditions. As a result of these limits on informed decision making, the argument concludes, consumers need a regulated health care system to keep costs down.

But, the problem of insufficient information exists even in a regulated health care system, claims Mr. Epstein. Moreover, he contends, regulatory limits on fees are bound to be set either so high as to reduce the supply of health care, or so low as to generate unnecessary services.

Mr. Epstein's aversion to the welfare state extends to the delivery of health care to people in dire straits. Society should not provide unlimited treatment to patients whose ailments are caused by such negative behaviors as substance abuse, he says, because free treatment is an incentive to engage in the adverse behaviors. Nor should society continue to provide unlimited terminal medical care—an area where he sees great potential for savings.

AIDS ISSUES

FBI nets seropositive physician. A hospital-owned clinic in San Francisco had a contract with the Federal Bureau of Investigation (FBI) to conduct physical examinations of FBI agents and candidates for agent positions. When the special agent in charge of the Bureau's San Francisco office learned that the clinic director, who performed the examinations, refused to refute an allegation of having AIDS, the special agent cut off the pipeline of examinees. The physician's protestation that he followed CDC and AMA guidelines for infection control did not budge the agent. The physician then went to court for an injunction, under the Rehabilitation Act, mandating the FBI to resume referrals to the clinic.

Initially, a federal district court judge issued a preliminary injunction prohibiting FBI disclosure of the physician's condition and ordering a resumption of the referrals. But, the Bureau's one-time cascade of referrals was limited to a trickle, and it appealed the order. By this time, the plaintiff's condition had deteriorated to the point where he stopped working. The Ninth Circuit Court of Appeals dismissed the claim for an injunction, holding that the claim now was moot, but remanded the case to the lower court for a determination of whether the special agent stopped the referrals due to his suspicion that the physician had AIDS or due to concerns over the physician's ability to conduct the examinations.

Pennsylvania hospital may disclose physician's identity. In a "look-back" case, a Pennsylvania Superior Court ruled that a trial court was correct in permitting two hospitals to disclose the identity of a seropositive resident in obstetrics and gynecology. The

disclosure was made to patients treated by the resident and to other physicians whom the resident may have assisted.

The resident's serostatus was learned when a cut through a surgical glove caused a patient's exposure to the resident's blood, and the resident voluntarily submitted to HIV testing at the request of one of the hospitals. After being informed of the test results, the resident informed appropriate officials and took a voluntary leave of absence.

The superior court found a compelling need for disclosure. Under the disclosure process, the resident's name was not revealed to the public.

HOSPITAL PRIVILEGES

Importance of following bylaws. A cardiac surgeon whose privileges were suspended due to high complication and mortality rates won $150,000 in damages from the hospital, and the award was affirmed by the Utah Supreme Court by a 3 to 2 vote. In a commentary in the *Hospital Law Newsletter*, editor Nathan Hershey noted that the hospital suffered from its cumbersome attempts to permit the surgeon to relinquish privileges voluntarily.

The termination of privileges followed an earlier suspension while the surgeon obtained additional training, and it followed new revelations of complications and a refusal by the hospital's anesthesiology and perfusion staff to work with the surgeon. The physician was given an opportunity to resign his elective cardiac surgery privileges, and he was provided with a meeting with the hospital's top administrators at which the revocation of privileges was spelled out and not protested. The offer to the physician to relinquish privileges voluntarily was significant, because the federal Health Care Quality Improvement Act, mandating reporting of privilege withdrawals to the National Practitioner Data Bank, was not yet in effect.

The jury's verdict was based on the hospital's departure from its own bylaw provisions governing privilege revocations.

BIOMEDICAL ETHICS

Disclosing brain death. Implementing the 1991 Declaration of Death Act, the State Board of Medical Examiners has adopted rules specifying how physicians are to go about declaring brain death. The neurologic criteria are: deep coma, marked by cerebral unreceptivity and lack of response; absence of brain stem functions; and irreversible cessation of brain functions. The attending physician and a neurologist or neurosurgeon must arrive independently at the determination of death. For babies younger than two months, the confirmation must come from a neonatologist, pediatric neurologist, or pediatric neurosurgeon.

The regulations include additional protections. Neither physician making the determination may be involved in a pending organ transplant affected by the declaration. Nor may a physician declare brain death if he has any reason to believe that declaration of death by neurologic criteria would violate the patient's religious beliefs.

Guidebook on advance directives. "A Guidebook for Health Care Professionals" on New Jersey's Advance Directives for Health Care Act and the federal Patient Self-determination Act has been published by the state Commission on Biomedical Ethics. The 1992 publication includes comprehensive information about the advance directives process, in an easy-to-follow format. To obtain a copy at no charge, MSNJ members may contact Addie Holden at MSNJ, 1/609/896-1766.

At press time, the Commission's own prospects appeared bleak. The panel was zero-funded for fiscal 1993 for the budget passed by the state Legislature. Chair of the Commission is Paul W. Armstrong, attorney for the families in most of the New Jersey Supreme Court right-to-die cases that began with the case of Karen Ann Quinlan. The vice-chair is Sister Jane Frances Brady, chief executive officer of St. Joseph's Medical Center in Paterson. □

James E. George, MD, JD; and Neil E. Weisfeld, JD, MsHyg

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BOOK REVIEWS

MAGNETIC RESONANCE IMAGING, SECOND EDITION

David D. Stark and William G. Bradley, Jr. St. Louis, MO, Mosby-Yearbook, 1992. When Stark and Bradley published the first edition of this text in 1986, it received much acclaim in radiological circles for its comprehensive presentation of magnetic resonance imaging (MRI). Even though MRI was yet in its infancy, that original work spanned an impressive 1,516 pages. Six years later, the editors have reassessed this fast-moving field in an updated version that constitutes one of the most extensive reviews of the subject. One thousand pages longer than its predecessor, this two-volume set embraces every aspect of MRI, from neuroaxis imaging to pediatric musculoskeletal scans.

The format of the text follows the pattern of the previous edition. The first 500 pages tackle MRI physics. The number of equations presented varies from chapter to chapter. The reader need not be put off by the complexities of higher mathematics because copious explanations accompany the equations.

The next three sections on the central nervous system consider the brain, the head and the neck, and the spine. Each section offers a detailed approach, enhanced by numerous state-of-the-art scans. Chapters on the thorax emphasize staging of neoplasms and the evaluation of cardiovascular disease. The techniques of the heart, including a discussion of the latest sequences, receive a thorough examination. Special attention is given to the liver in a section devoted to abdominal imaging. In particular, the text explores MRI's superiority to computed tomography (CT) in the evaluation of certain lesions, such as hemangiomas. As in the original edition, the text contains a well-documented review of the musculoskeletal system and pelvis.

Greatly expanded, but without sacrificing the organizational approach of the first edition, this book is highly recommended. □

Neil B. Horner, MD

PUBLIC HEALTH AND PUBLIC HEALTH SERVICES

Dona Schneider; Michael R. Greenberg; Bernadette West. New Brunswick, NJ, Rutgers University Press, 1992. Three public health professionals accomplished the Herculean task of gathering information concerning the status of diseases and conditions that account for mortality and morbidity in the United States and compared the national situation with that which exists in the New York metropolitan area, including part of northern New Jersey. To no one's surprise, the news is mostly bad, particularly in view of the fact that we spend more for health care than any other nation. This sad state of affairs is best illustrated by our high infant mortality rate. Another embarrassing statistic of local interest is that blacks in northern New Jersey have the highest mortality rate in the metropolitan area. If there is any consolation among all these dismal figures, it is that cancer mortality is no worse in New Jersey than anywhere else in the United States.

Clinicians may be disappointed that this book does not delve deeply into explanations, but the authors do suggest that our utilization or over-utilization of the newest and latest sophisticated biomedical procedures and machines partly explains our ris-

ing expenditures of hundreds of billions of dollars; only a mere $20 billion can be attributed to purely defensive medicine. The following quotation precedes the first chapter and succinctly contributes to an understanding of our present dissatisfaction: "AIDS, drug abuse, poverty, violence, racism, vermin, homelessness ... synergistically overwhelm our fragmented public health, education, and social infrastructure."

This monograph is recommended for anyone who bears any responsibility for health care and particularly for public officials who control the means of enforcing present laws and implementing changes so that future editions will be less embarrassing. ☐
Jerome Abrams, MD, MPH

UNCHARTED SEAS

Fuller Albright and Read Ellsworth (D. Lynn Loriaux, ed). Portland, OR, Kalmia Press, 1990.
Fuller Albright (1900-1969), the quintessential clinical investigator, made numerous original contributions to medicine, e.g. he was the first to describe postmenopausal osteoporosis; he introduced the concept of hormone resistance in his paper on pseudohypoparathyroidism. His achievements are even more remarkable when one considers that his career was hampered by the devastating effects of postencephalitic parkinsonism, a consequence of having contracted von Economo's encephalitis during an epidemic in 1918. Tremors first appeared when he was 36 years old. By age 40, Albright no longer could write; by age 45 his speech was severely impaired. To aggravate matters, he suffered a stroke in 1956, and spent his remaining years in a vegetative state.

Albright's manuscript, *Uncharted Seas,* was discovered among papers donated by his wife to the Countway Library in Boston. While Ellsworth's name also appears on the title page, the manuscript seems to have been written solely by Albright. Thus, Ellsworth's contribution is unknown. The book was intended for the educated layman, much like *Microbe Hunters* by Paul de Kruif and *Rats, Lice and History* by Hans Zinsser.

With lucid prose and clever metaphors, Albright describes the evolution of our knowledge about the parathyroid glands and their role in calcium metabolism. He skillfully interweaves his philosophy of science with the poignant story (origin of the title) of one of his patients, a sea captain named Charles Martell, who suffered from a parathyroid adenoma. In doing so, Albright reveals how we can bridge the gap between scientific research and the actual world of real patients. Surely, this is a pertinent lesson for the modern disciples of Cosmas faced with an ever-increasing technology that is widening that gap.

We are indebted to Dr. Loriaux who has done a great service by rescuing this book from oblivion. He has written an excellent introduction that succinctly captures the essence of Albright and, in a masterful job of editing, has succeeded in the difficult task of converting a rough draft into a style indistinguishable from Albright's other published works.

Dr. Loriaux is concerned that clinical science is declining in America. Where can the next generation of clinical researchers look for example and inspiration? *Uncharted Seas* is a good start. ☐
Vincent J. Cirillo, MS

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EDITOR'S DESK

AUGUST

Spenser wrote: "The eighth was August, being richly arrayed in garment all of gold, down to the ground."

August, the eighth month, with fields ripe for harvesting, with summer evenings carrying a hint of autumnal chill and mothers dreaming of the ringing of school bells, is upon us.

The month was originally Sextilis, the sixth month, and consisted of 29 days. Octavian, grandson of Julius Caesar's sister and designated Julius' heir, was named emperor in 29 B.C. Two years later the Roman senate gave Octavian the title "Augustus," meaning "venerable" or "reverend," an appellation adopted by succeeding emperors. The Senate also agreed to have Sextilis renamed for Augustus. Although Octavian had been born in September, many of his greatest triumphs had occurred in "August." And he wanted his month to follow immediately after the month of the great Julius. In order to equalize the importance of his month, Augustus borrowed one day from September and one from February, thus producing the only consecutive months with 31 days in the calendar year. (December and January do not count.) Coincidentally, Octavian Caesar Augustus died in August in 14 A.D.

At 0800 hours on Friday, August 3, 1492, Columbus sailed the *Niña, Pinta,* and *Santa María* from Palos, Spain, onto the ocean blue in an attempt to find a westerly route to the rich East Indies trade. The sailing ships transformed the history of the world; it certainly opened our world. It was, as described by Dr. Lionel Casson of New York University, "the earliest example of the use



Howard D. Slobodien, MD

of energy other than muscle, either animal or human." Interestingly, on the same day that Columbus sailed, August 3, but in 1958, the world's first nuclear submarine, the *Nautilus,* cruised beneath the North Pole. Five hundred years from now, which of these two seminal August 3 voyages will be deemed more important?

Joseph Miller, aged 54, died on August 5, 1738. As his tombstone noted, he was "a tender Husband, a sincere Friend, a facetious Companion, and an excellent Comedian." Miller was considered a fine actor, but he was innocent, very proper, and incapable of joking. His contemporaries, in jest, ascribed every new bit of wit or repartee to him and he became the best friend to succeeding comedians, the reputed author and originator of *Joe Miller's Joke Book.* In such devious ways are reputations developed.

On August 10, 1792, two hundred years ago, a Parisian mob stormed the palace and butchered its inhabitants, including the loyal Swiss Guards. This was the true beginning of the French Revolution. The royal family had fled the palace for the promised sanctuary of the Legislative Assembly; it was their last day of freedom, the journey ending at the guillotine. (Napoleon Bonaparte was born on August 5, 1738, in Ajaccio, France.) Sic semper tyrannis.

One hundred years ago, on August 17, 1892, Mae West was born. She rose from burlesque roots to become one of the queens of the silver screen, the embodiment of a gay nineties femme fatale. Many will remember her for the phrase, "Come up and see me sometime." Others will think of her as a life-saver—actually an inflatable life vest used extensively during World War II and named after her because of the resemblance seen in the pneumatic appearance of the vest. The inflatable jackets demonstrated on every commercial flight are derivations of the original "Mae West."

Of somewhat more importance was the ratification, on August 26, 1920, of the 19th Amendment to the Constitution of the United States: "The right of citizens of the United States to vote shall not be denied or abridged by the United States or by any state on account of sex. Congress shall have power to enforce this article by appropriate legislation." On an August day more than 50 years later, Women's Equality Day was declared. Neither the amendment nor the declaration has produced true equality between the sexes; it will take continued sustained efforts by all of good will to accomplish that, if we do not get bogged down during our deliberations by trying to differentiate sex from gender.

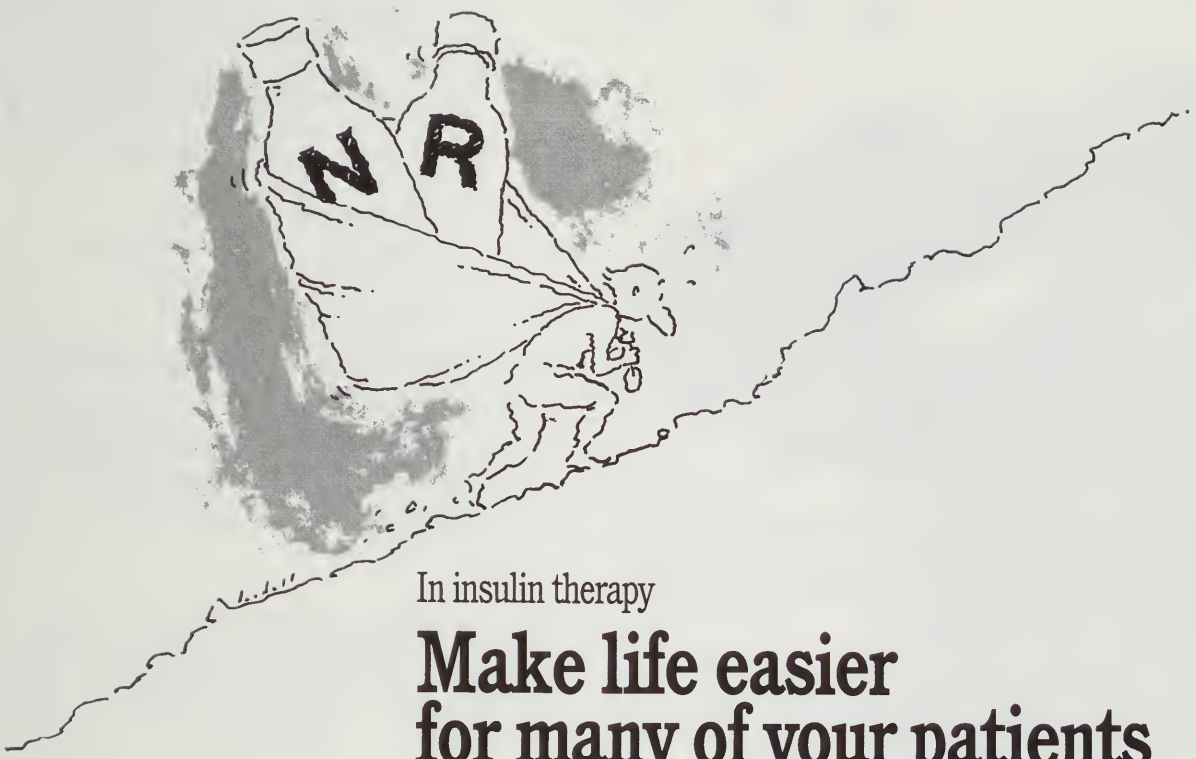
Finally, August 4, 1735, commemorates the acquittal of John Peter Zenger. Zenger was a printer who had been apprenticed to William Bradford, first printer in the New York province. Bradford established the *Gazette*, the first newspaper in the colony and loyal to the government. Zenger was more of an iconoclast. He was befriended and financed by opponents of the government and established the *Weekly Journal.* In its pages he criticized William Crosby, governor of New York, who apparently tried to enrich himself by manipulating the legal system. As a result, Zenger was accused of libel.

One of England's central courts, the Star Chamber, abolished in 1641, had declared in 1606 that an accurate statement against the government was worse than a deceitful one; the former created scandal, the latter merely breached the peace. (Even the noted Blackstone declared in the middle of the 18th century that matters could be considered libelous despite their truth or falsity.) So the government rejected the appeal of Andrew Hamilton, the Philadelphia lawyer defending Zenger, to use the truth of the printed articles as a defense. But Hamilton, in a classic presentation, asked the jury to render a verdict according to the truth and for them, rather than the judiciary, to determine what constituted seditious libel. The not guilty verdict undid some of the powers of common law judges and other British officials to harass American newspapers. However, freedom of the press was far from guaranteed and legislators still prosecuted printers. The first amendment to the Constitution of the United States, adopted in 1791, based on Section 12 of the Virginia Constitution (1776), helped, but the Alien Act and the Sedition Act of 1798, which produced a "Reign of Terror" at that time, were interpreted broadly enough to be used against Republican critics of the government; leading journalists and even a congressman were prosecuted. The Alien Act expired in 1800 and the Sedition Act in 1801. They did not die quiet deaths, but die they did. The resulting "freedom of the press is one of the great by-products of liberty, and can never be restrained but by despotic governments," as stated in the Constitution of Virginia.

There is a John Peter Zenger room in the Federal Hall National Monument on Wall and Nassau Streets in New York City. □
Howard D. Slobodien, MD

Every summer is headed for a fall. Anon

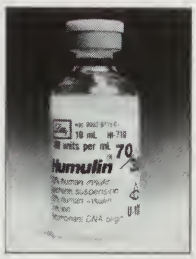
The printing press is either the greatest blessing or the greatest curse of modern times, one sometimes forgets which.
J.M. Barrie,
Sentimental Tommy (1896)



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The Migrant Farmworker: Health Care Challenge

Kathy Freudenberg, MA

Migrant farmworkers comprise a severely medically underserved population, both nationally and in New Jersey. This article defines the migrant population, reviews their specific health problems, and illustrates the urgent need for the medical community's attention and resources.



Kathy Freudenberg, MA

Migrant farmworkers comprise a unique and often forgotten minority group in New Jersey. As a transient population, they are easily overlooked, toiling and living in the less visible rural areas where agriculture predominates. New Jersey Rural Opportunities, Inc. estimates that the state has an annual migrant/seasonal farmworker population of over 12,000 persons. Theirs is a difficult plight, characterized by poverty, extreme mobility, arduous labor, severe occupational hazards, educational disadvantages, and language differences. The picture becomes even more grim when one factors in the migrants' lack of political empowerment and self-advocacy skills.

Migrant workers represent a critical link in the food production chain of the state. They help farmers produce and harvest an abundance of fruits and vegetables for which New Jersey is well known. Beyond that, they pump money into the local economy by purchasing goods and services, and allow local communities to receive state and federal funds to operate farmworker services. It is ironic that while migrants work to provide nutritious foods for New Jersey residents, migrant workers have far greater health problems than the general population.

Health research on migrant workers has been limited, partly because their mobility precludes long-term studies, but also because research funding, staff, and priority status are scarce. Nevertheless, statistics are available that graphically illustrate the problems faced by migrant workers throughout the country:

1. The infant mortality rate is 25 percent higher than the national average.

2. The death rate from influenza and pneumonia is 20 percent higher than the national average, and the death rate from tuberculosis and other communicable diseases is 25 times higher than the national average.

3. The hospitalization rate from accidents is 50 percent higher than the national average.[1]

4. The migrant farmworker population suffers health problems related to poor sanitation and overcrowded living conditions at a rate much higher than the non-farmworker population.

5. Parasitic infections afflict migrant workers an average of 20 times more than the general population, ranging in prevalence from 27 to 57 percent (rates comparable to those reported in third world countries).

6. The full extent of both acute and chronic pesticide poisoning among farmworkers still is not known.

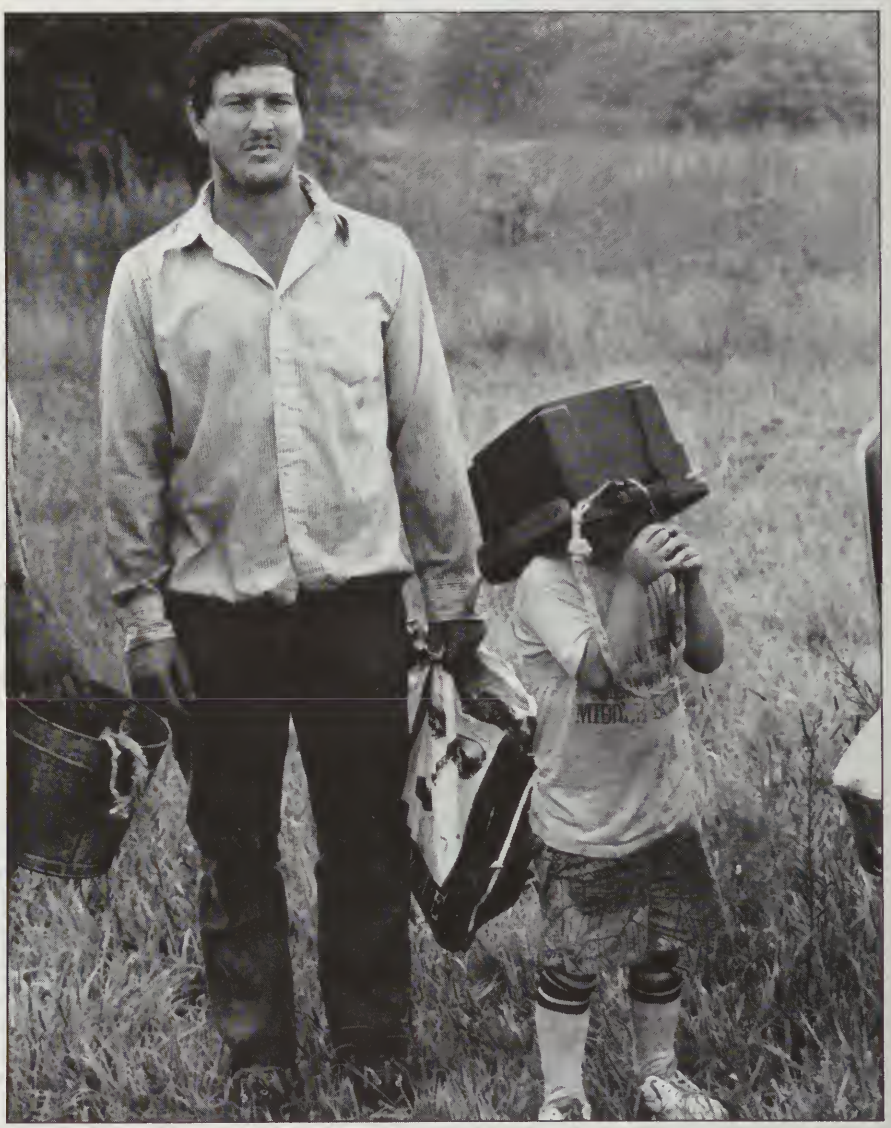
7. The dangers of agricultural labor on women, particularly pregnant farmworkers and their newborn babies, and on the development of farmworker children, are poorly documented.[2]

The most sobering statistic, and one that demands acknowledgment of the urgent need to address migrant health issues, is that, in 1990, the average life expectancy for a migrant farmworker was 48 years.[3]

In New Jersey, two migrant



Migrant farmworkers at "home" and in the field. © Peter Byron

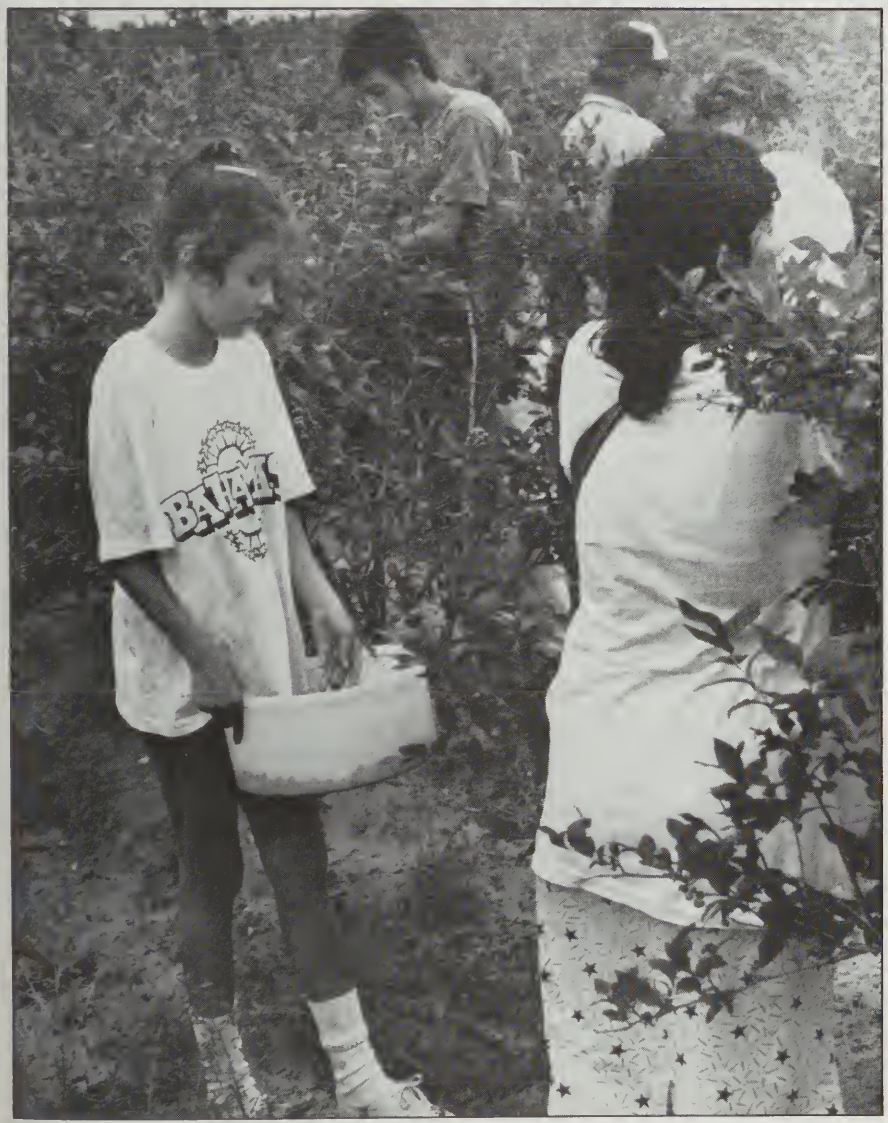


health centers are in operation, funded largely by federal public health service act grants. However, obstacles such as insufficient funding, lack of client transportation, and language differences prevent the clinics from reaching a large portion of the potential clientele. According to a 1986 report of the Farmworker Justice Fund, in fiscal year 1985 federally funded migrant health facilities reached only 17 percent of migrant and seasonal farmworkers and their dependents.[2]

The health problems most frequently reported at migrant health clinics include dermatitis, injuries, respiratory problems, musculoskeletal ailments, eye problems, gastrointestinal problems, hypertension, and diabetes. Most health problems can be linked directly to the workplace or migrant lifestyle—overcrowded housing, poor sanitation, exposure to pesticides, stoop labor, improper nutrition, or accidents related to occupational hazards.

To fully appreciate the severity of this population's health needs,





Migrant farmworkers are adults and children. © Peter Byron

it is necessary to consider the most prevalent of their health problems. The Farmworker Justice Fund described the following major concerns:

Poor sanitation. Numerous health problems arise from poor sanitation in the field and in living quarters, including communicable diseases, dermatitis, heat disorders, parasitic infections, and pesticide-related illness. Farmworkers are three to five times more likely to contract a urinary tract infection than the general population.

Heat stress. Agricultural workers are over four times more likely than nonagricultural workers to suffer heat disorders. Problems range from prickly rash to fatal heat stroke.

Pesticide exposure. Most labor-intensive crops receive heavy pesticide application, leaving migrant field workers at great risk of exposure. Contact with pesticides may result in acute problems such as poisoning, skin and eye conditions, chronic dermatitis, headaches, cancer, birth defects, and abnormalities in



Typical housing accommodations for migrant workers. © Peter Byron

liver and kidney function in farmworkers of all ages.

Vision problems. Occupational hazards for the eyes include irritations, infections or injury from sun and wind; dust, soil, twigs, branches, thorns, and debris ejected from farm machinery; and allergic reactions.

Musculoskeletal conditions. Migrant farmworkers perform heavy labor, and often must stoop or kneel for extended periods or lift and haul heavy loads. Prolonged activity of this type ultimately leads to muscle strain, traumatic injury, irritated joint tissue, and degenerative joint disease.

Accidents. Agriculture is widely considered to be the second most dangerous occupation in the United States, second only to mining. In 1983, there were 1,800 work-related deaths and 180,000 disabling injuries among workers aged 14 and over.

Respiratory conditions. Migrant workers frequently live in overcrowded, poorly ventilated housing and lack sanitary conditions, resulting in the spread of colds, influenza, and upper respiratory tract infections. Migrant workers also are more likely to inhale hazardous substances.[2]

Among the many other factors affecting migrant health are poor nutrition; little or no access to adequate pre- and postnatal care; inability to qualify for Medicaid benefits outside the homebase state; overwhelming lack of health insurance; geographical isolation from health care providers; substance abuse; and illiteracy. Many migrant farmworkers and families cannot access preventive or routine health care, and seek treatment only for acute medical problems, often in emergency rooms.

In many respects, New Jersey is far ahead of other states in protecting the rights and welfare of migrant workers. New Jersey is 1 of 15 states providing complete coverage for agricultural workers under worker's compensation law. New Jersey also protects farmworkers against pesticides more extensively than the federal government, and has passed toxic substance right-to-know legislation.[2] A 1987 study conducted in New York, New Jersey, Ohio, and Pennsylvania by Rural Opportunities, Inc. revealed that farmworkers surveyed in New Jersey had the lowest incidence of occupational injuries, suggesting better working conditions and stronger law enforcement than elsewhere. Fifty-seven percent of migrant workers reported receiving pesticide safety information from New Jersey health care providers.[4]

New Jersey also has a statewide farmworker health task force that encourages cooperation among member agencies.[5] The federally funded migrant education program provides health services for the children of migrant workers, and has established substantial links with the health care community. SaLantic Health Services, Inc. and Bridgeton Area Health Services, Inc. are direct health care providers for migrant and rural populations. New Jersey Rural Opportunities, Inc., the Comité de Apoyo a los Trabajadores Agrícolas (CATA), farmworkers' rights organizations, and other agencies advocate on behalf of migrant farmworker needs and rights.

However, much remains to be done. The extremely limited resources available for migrant



Farmworkers getting ready for a day at work. © Peter Byron

health care projects hamper the ability of agencies to deliver comprehensive services to the majority of the state's migrant workers, resulting in a seriously underserved population. Delivery of acute care must be coupled with systematic preventive care based on a whole-family approach that includes screening, immunizations, health and nutrition education, and outreach into remote areas.

If migrant families are unable to get to health care centers, the services must be taken to them. More work must be done to bring about greater public consciousness of the existence and needs of migrant workers. The health care community, in particular, must become more aware of their specific health problems.

The situation is summarized succinctly in the 1987 Rural Opportunities, Inc. study on farmworker health care availability and utilization: "No other labor force in the United States is expected to tolerate (nor indeed has tolerated) such dangerous, degrading working and living conditions as farmworkers."[4]

The case for remedying the situation is stated by the Farmworker Justic Fund, Inc. in its 1988 progress report: "The time is well past due for this nation to afford farmworkers decent health care. It should be apparent to all thoughtful observers that farmworkers, the most productive sector of labor in one of America's most successful industries, should not be rewarded for their efforts with disability and disease. Farmworker health and safety must become a national priority."[6] ■

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Ms. Freudenberg is director of special projects, Gloucester County Special Services School District.

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Address reprint requests to Ms. Freudenberg, Gloucester County Special Services School District, Herbert Building, PO Box 8, Sewell, NJ 08080.

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Maximum Voluntary Cough Ratios Reflect Antitussive Activity of Inhaled Albuterol

Burton M. Cohen, MD

The author calculates the maximum expiratory flow rate during forced exhalation as a proportion of that which can be achieved with a voluntary cough (the cough ratio), noting the lower figures with bronchial asthma and rises due to the antitussive effects of a standard inhaled bronchodilator.

Beardmore suggested that maximum voluntary cough produces a respiratory profile incorporating the characteristics of a maximum expiratory flow volume (MEFV) curve, with the rate of change of cough peak flow with lung volume, the cough slope (CS), reproducible for a normal individual on a day-to-day basis; when MEFV and cough curves are superimposed and aligned at functional residual capacity, the ratio of MEFV flow rate to peak cough flow rate measured at the same lung volume, the cough ratio (CR) is considered a dimensionless measure of airway function (Figure 1).[1] Because Beardmore did not examine the response of CR to disease and therapy, the authors validate these observations, and test the worth of changes in this measurement as an expression of antitussive effect of albuterol, a standard inhaled bronchodilator.

METHODS

Our apparatus was a self-contained mobile respiratory function analyzer incorporating a rapid-response linear nitrogen analyzer, two Fleisch-type pneumotachographs, solid-state computing circuits, four sets of digital displays, and a large format X-Y recorder (Hewlett-Packard Model 47402A, Vertek Series 6100VR). MEFV curves were obtained in the "VCf" mode in which the output of the No. 3 pneumotachograph was applied to a capacitance-type pressure transducer that converted pressure into an electrical signal that was processed, amplified, and converted into digital form; a digital integrator coverted the flow signal into a volume signal. Sensors adjusted the flow signal to correct the readings at ambient pressure in the breathing tube between apparatus and patient to BTPS and the circuit was automatically zeroed after each maneuver. The time base for the timer and recorder automatically was triggered when the flow rate exceeded 0.3 l/sec.[2,3] A constant volume history was maintained by having the subject inspire to total lung capacity (TLC) and then expire to functional residual capacity (FRC). Forced vital capacity (FVC), forced expiratory volume for the first second 1.0, and the maximum expiratory flow rate (MEFR) were read from the digital displays, and the peak expiratory flow rate (PEFR) measured from the curves. The cough sequence was obtained by aligning the apparatus to FRC and "instructing the subject to inspire fully to TLC and then to cough as forcefully as possible to respiratory volume without intervening respirations between the individual cough efforts."[1] The ratios of MEFV flow rates to the peak cough flow rates, measured at the same lung volumes on CS, were determined at 50 and 75 percent FVC and at the end expiratory (EE) flow rate for each subject.

Fifty-one adults were studied. There were 39 healthy adults, 22 men and 17 women, ranging in age from 22 to 79 years. Twelve patients, 7 men and 5 women had stable bronchial asthma[4] with a potentially reversible physiologic component determined on prior isoproterenol aerosol testing;[5] mean age was 51.3 years, with a range of 31 to 74 years. MEFV and cough sequence curves were made in the morning for the fasted subjects. Asthmatic patients reported without taking their regular daily medications. After control traces, the asthmatic patients were each given two inhalations of albuterol (0.18 mg) from a commercially obtained metered dose inhaler (Proventil Inhaler, Schering Corporation, Kenilworth), and MEFR and cough traces were repeated 15 minutes later.

RESULTS

The demographic data, means,

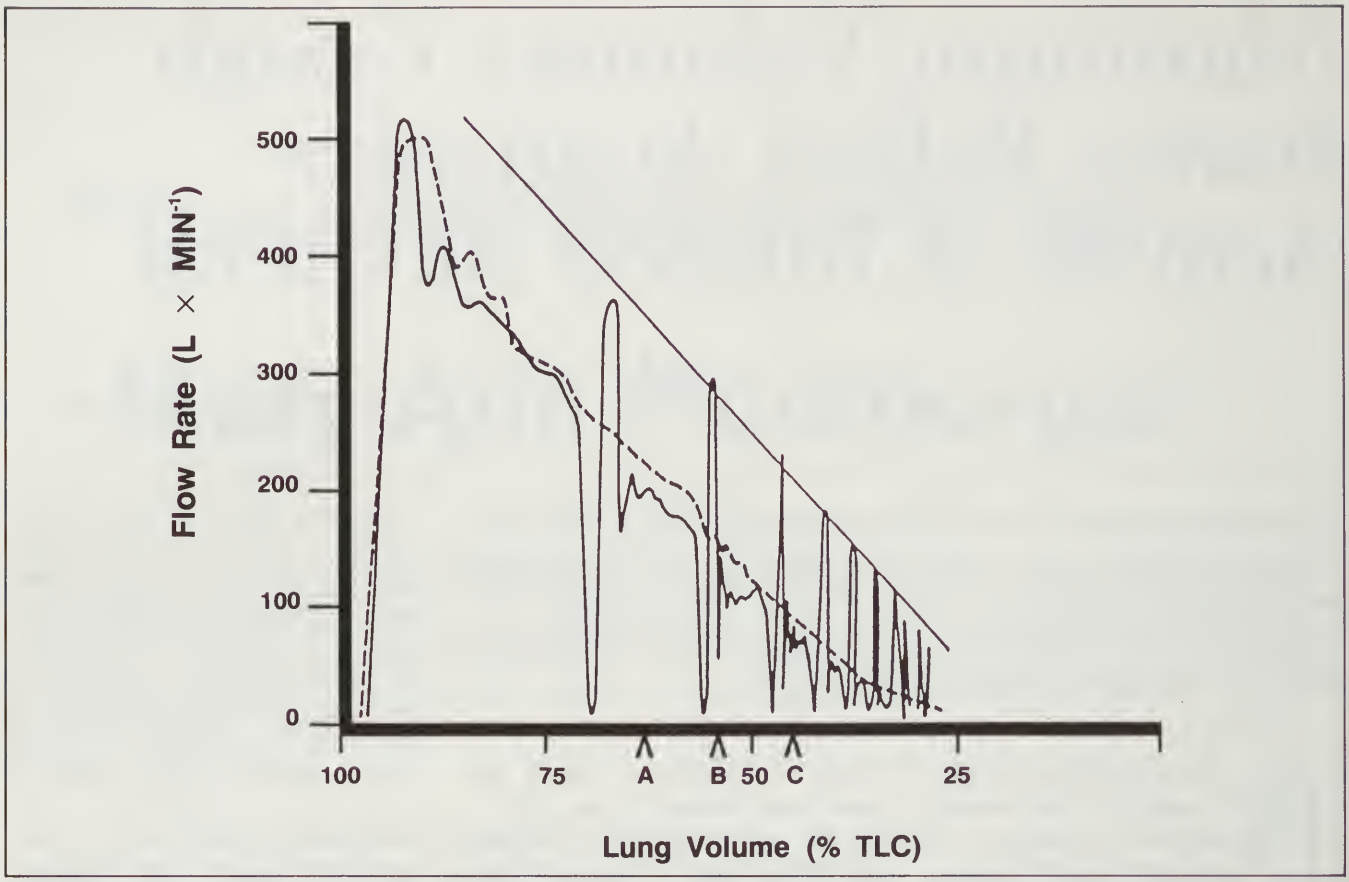


Figure 1. Flow-volume curve of cough sequence from a healthy adult female. Points A and C represent 50 and 25 percent vital capacity, respectively, and point B represents the resting end expiratory level. The line through the peak flow of successive cough efforts has been drawn by eye. The dashed line represents the maximum expiratory flow-volume curve from the same subject, superimposed.[1]

and standard deviations for the pulmonary function and CR variables for the 39 healthy adults are summarized in Table 1 by sex, with the statistical significance of the male-female differences in cough indices. Individual cough sequences comprised from 3 to 17 separate rate efforts with a mean of 10.7(±3.28) for the entire group. While ages did not differ, women showed a higher CR at 50 percent FVC, a lower mean at 75 percent, and no difference from the male mean at EE. When CRs at EE were plotted against age (Figure 2), they did not show the steady linear decline after age 18 as noted by Beardmore.[1] At baseline, asthmatic patients were slightly younger, and CRs were significantly lower ($P = 0.05$ or better) throughout. Fifteen minutes after the albuterol inhalation, all physiologic means rose significantly, with the percent increments in CRs of greater magnitude than those for the three respiratory functions analyzed (Table 2). Figure 3 shows the changes in individual EE means schematically for these 12 patients. Mean cough sequences were 11.40 ± 4.54 before, and 8.90 ± 3.62 after, albuterol.

Table 1. ***Mean demographic data, pulmonary function indices, and cough ratios for 39 healthy nonsmoking adults.[4]***

Index	Male	Female
Number	22	17
Age (years)	57.9 (12.2)	55.5 (13.2)
Height (inches)	69.3 (2.26)	65.5 (1.79)
Weight (pounds)	180.6 (19.0)	144.2 (24.8)
FVC (cc)	4018.6 (906.4)	2422.2 (1153.8)
$FEV_{1.0}$ (cc)	2817.0 (675.6)	2032.5 (722.2)
MEFR (1/sec)	6.07 (1.98)	4.21 (1.39)
PEFR (1/sec)	7.30 (1.40)	5.12 (1.52)
CR 50%	1.281 (0.81)[1]	1.526 (1.34)[1]
CR 75%	0.892 (0.815)[2]	0.779 (0.454)[2]
CR EE	0.902 (0.934)[3]	0.964 (0.587)[3]

1. Male-female difference statistically significant at the 0.01 level.
2. Male-female difference statistically significant at the 0.05 level.
3. Male-female difference not statistically significant.
4. Standard deviations in parentheses.

DISCUSSION

Although newer techniques utilizing capsaicin[6] and low chloride solutions[7] provide less intense

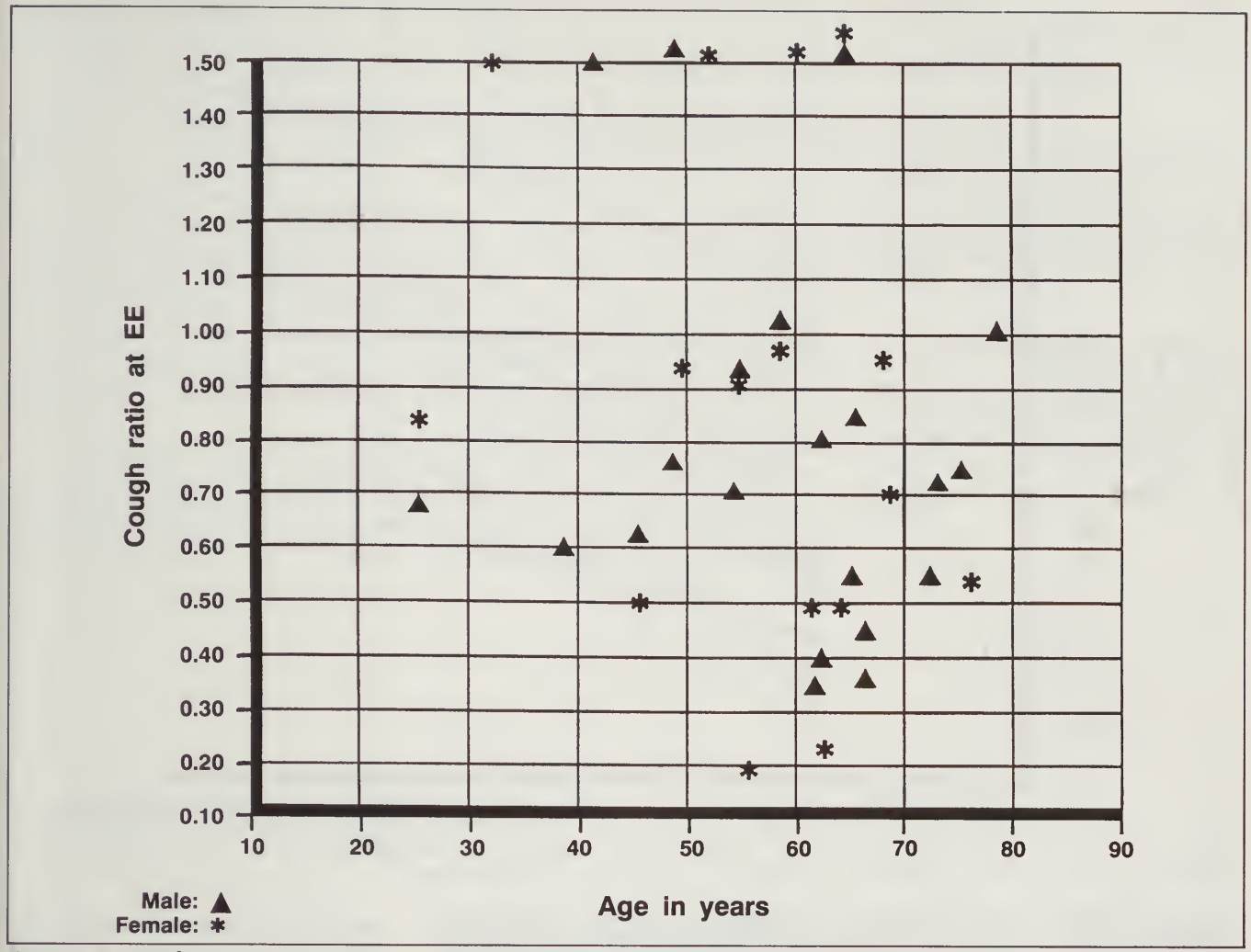


Figure 2. Cough ratio at EE against age for all normal subjects, male and female.

stimuli for artificially induced human cough production than our original citric acid challenge,[8] none of these approaches are ideal. In our normal subjects, the threshold dose of citric acid able to elicit cough was markedly variable, and even 10 percent of those given the highest dose did not respond; the tussive response to this stimulus may be fully repressed during sleep.[9] While inhalation of ultrasonically nebulized distilled water-induced cough and bronchoconstriction in asthmatic subjects and cough only in normal subjects, 25 percent of the latter did not cough with the aerosols.[7] Higher inspiratory flow rates may attentuate the cough stimulus[10] while the behavior of the cough response in asthmatics may be related to the degree of observed bronchoconstriction, which may depend on diurnal variation in lung function.[11]

The use of directed (voluntary) cough, rather than paroxysms stimulated in inhalation challenges (aerosol, dust, or vapor) obviates many of the difficulties of variable responsivity, threshold, and time of day.[12] Beardmore stressed the advantage of using CR information over measurements made from conventional MEFV maneuvers alone for healthy adults, particularly if the plots are made at EE rather than at standard lung volumes.[1] In his view, each subject functions as his own standard, and, since the ratios are dimensionless, it is easier to compare subjects of differing physical characteristics than if absolute flow rate tables are consulted. Although our mean CRs at 50 and 75 percent FVC differed for men and women, the group means calculated at EE were similar. Our healthy individuals did not show the steady decline in EE during adult life noted by Beardmore.

Just as a fall in CR brought about by a greater reduction in MEFV-equivalent flow rate than in cough peak, flow at any lung volume was noted by investigators for their few asthmatic subjects; we observed lower CRs for our 12 asthmatics at all three lung volumes (50 and 75 percent for FVC and EE) than for our healthy participants. For these patients, the bronchodilating effect of single doses of albuterol was accompanied by a decrease in cough frequency and rises in CRs. In an earlier randomized, blinded trial of the responsivity of nine expirographic and airway indices to antitussive therapy of otherwise healthy adults with common colds, changes in cough pressure at peak flow (termed the cough index) were of greater magnitude than those for com-

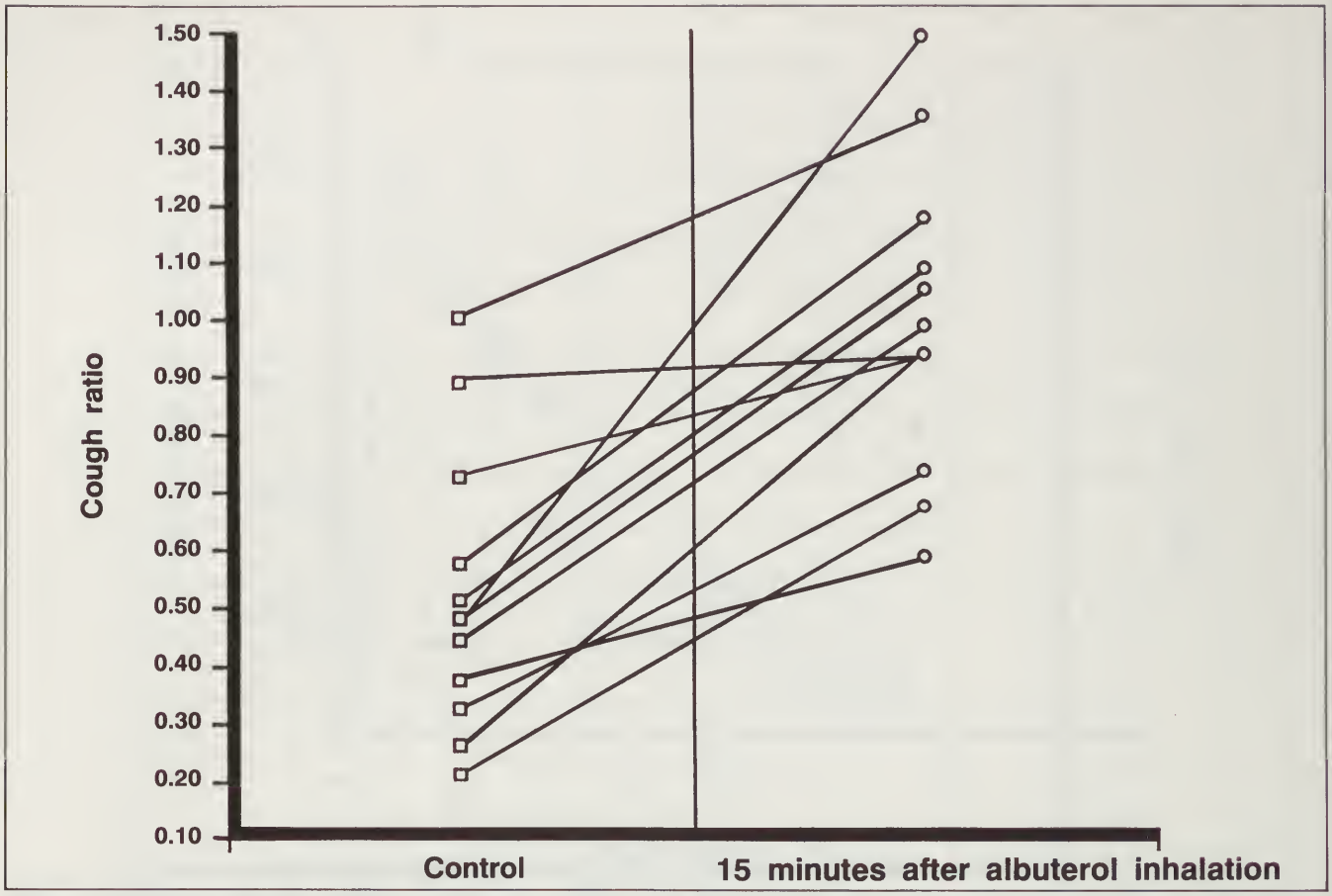


Figure 3. Changes in EE cough ratios for 12 adults with bronchial asthma before, and 15 minutes after, two inhalations of a commercial albuterol mist given by metered dose nebulization.

Table 2. ***Mean demographic data on entry, pulmonary function indices, and cough ratios for 12 asthmatic adults at control, and 15 minutes after, two inhalations of a commercial albuterol aerosol given from a metered dose inhaler.***[4]

Index	Control	15 Minutes after Inhalation
Age (years)	51.3 (13.7)	
Height (inches)	67.8 (3.17)	
Weight (pounds)	176.1 (15.7)	
Number of coughs	11.4 (4.54)	
FVC (cc)	3727.0 (917.5)	4211.5 (1097.7)
% change		+12.9[1]
$FEV_{1.0}$ (cc)	2570.0 (688.7)	3060.0 (636.0)
% change		+19.1[2]
MEFR (1/sec)	5.72 (1.31)	—
PEFR (1/sec)	6.83 (1.16)	8.21 (0.91)
% change		+20.4[2]
CR 50%	0.811 (0.309)	1.642 (1.049)
% change		+100.2[3]
CR 75%	0.656 (0.256)	1.255 (0.351)
% change		+91.3[3]
CR EE	0.564 (0.210)	1.022 (0.275)
% change		+77.7[3]

1. No statistical significance for the comparison.
2. Statistically significant at the 0.05 level.
3. Statistically significant at the 0.01 level or better.
4. Standard deviations in parentheses.

mon spirographic indices.[13] In the present trial, increases in $FEV_{1.0}$ and PEFR, while compatible with acceptable bronchodilation,[14] were of lesser magnitude than the increments in CRs. This behavior suggests that the relief of bronchospasm in our asthmatic patients was accompanied by significant measurable improvement in cough. ■

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Dr. Cohen is clinical professor of medicine, UMDNJ-New Jersey Medical School, Newark. The paper was submitted in January 1992 and accepted in March 1992. Address reprint requests to Dr. Cohen, 425 Westfield Avenue, Elizabeth, NJ 07208.

Monocyte Activation in Acquired Immunodeficiency Syndrome

Frank J. Ferraro, MD
Charles R. Spillert, PhD
Flor Tecson-Tumang, MD
Eric J. Lazaro, MD

The monocyte plays a key role in the pathophysiology of AIDS and ARC. This preliminary report adds insight into monocyte activation associated with HIV seroconversion, by comparing recalcification times in healthy controls and HIV-positive patients.

Several investigators have documented a variety of abnormalities in monocyte function in patients with acquired immunodeficiency syndrome (AIDS). These include: defects in monocyte number, in phagocytosis, in secretory products, and in monocyte-T cell interactions.[1-3] Recent evidence has stressed the important contributory role of the monocyte to the extrinsic pathway of the coagulation process. Isolated monocytes have been shown to generate procoagulant activity in healthy individuals as well as in individuals with a variety of diseases and conditions, even if not stimulated with endotoxin.[4] Techniques for demonstrating this property of the monocyte have been laborious, expensive, and not adaptable to routine clinical application. Incubation of citrated blood with endotoxin at increasing concentrations for increasing periods of time results in a proportionately reduced recalcification time (RT) due to procoagulant generation.[5] It is well established that many disease states are associated with accelerated coagulation that may be related to the generation of monocyte procoagulant activity when compared to normal controls. Since the monocyte is the only circulating cell capable of generating this procoagulant activity, the addition of endotoxin to whole blood induces procoagulant release that serves as a marker of monocyte activation.[6] It also should be emphasized that monocyte procoagulant activity is directly related to prior activation of this cell in vivo. This information, together with utilization of a sensitive coagulation instrument, the Sonoclot Coagulation Analyzer (Sienco, Morrison, Colorado), permitted the development of a simple, reliable, and clincially applicable test to measure endotoxin-activated RT. This test has been utilized in a variety of states in which hypercoagulability plays a basic pathophysiologic role.[7-10] The purpose of this report is to determine whether the unstimulated or endotoxin-activated recalcification times are altered in AIDS-related complex (ARC) and AIDS.

MATERIALS AND METHODS

This study received institutional review board approval and informed consent was obtained from each patient upon entering the study. Patients entered into this study were derived from the AIDS section of the Infectious Disease Unit at the Veterans' Administration Hospital, East Orange. Healthy volunteers served as controls. Since the monocyte is the only blood cell capable of generating procoagulant activity, the incubation of citrated blood with either saline (control) or endotoxin (monocyte activator) followed by determination of RT should yield a measure of monocyte activation. Citrated blood from 19 healthy volunteers, 22 volunteers with early ARC (EARC), 9 volunteers with late ARC (LARC), and 7 volunteers with AIDS was incubated with 20 µl saline containing 10 µg endotoxin. After incubation at 37°C for two hours, RTs were measured. Peripheral venous blood (4.5 ml) was drawn into siliconized glass tubes containing 0.5 ml of buffered citrate. Citrated whole blood (1.0 ml) was added to plastic tubes containing either 20 µl saline or 20 µl saline containing 10 µg of *Escherichia coli* endotoxin 055:B5W No. 3120-25 (Difco, Detroit, Michigan). The blood samples were incubated at 37°C for two hours and then 40 µl of 0.1 M calcium chloride ($CaCl_2$) was added to 300 µl of the incubated blood. The addition of $CaCl_2$ initiates the process of clotting. Using the Sonoclot Coagulation Analyzer, changes in the impedance in the clot were plotted as a function of time. RT was defined as the time, in minutes,

Table. ***RTs in ARC and AIDS patients.***

Groups	*RTS*	*RTE*
	Mean (min) SD	*Mean (min) SD*
Controls (n = 19)	(A) 6.6 +/– 0.8	(E) 5.7 +/– 0.8
EARC (n = 22)	*(B) 5.5 +/– 1.3	**(F) 4.1 +/– 0.8
LARC (n = 9)	*(C) 4.7 +/– 1.3	**(G) 4.4 +/– 0.9
AIDS (n = 7)	*(D) 5.1 +/– 1.3	**(H) 4.2 +/– 0.8

*$P < .05$ vs. controls (RTS)
**$P < .05$ vs. controls (RTE)

necessary for the clot to produce an impedance rise of one inch from the baseline recording. RTs of the saline (RTS), as well as the endotoxin (RTE)-stimulated sample, were measured. The analysis of variance for unpaired observations with a *P* value of less than .05 was considered significant.

RESULTS

The changes in the RTS and RTE of the controls compared with the EARC, LARC, and AIDS patients are recorded in the Table.

There was a significant reduction in the RTS and RTE values in patients as compared to controls. However, there were no significant differences in these values as a function of disease severity.

The lowest values of RTS and RTE for healthy controls were 5.3 and 4.5 minutes, respectively. If one considers values shorter than these as abnormal, it was found that 81 percent of EARC patients, 89 percent of LARC patients, and 100 percent of AIDS patients had at least one abnormal value of RTS and RTE.

DISCUSSION AND CONCLUSIONS

It is not unexpected that RTS and RTE coagulation parameters are reduced in all stages of ARC because these data are obtained on whole blood. ARC is a state of immune dysfunction; the monocyte (an immune cell) is activated and generates a multitude of chemical mediators including tissue factor. Reduced clotting times are expected.

Pauza suggested a hypothesis concerning the pathogenic mechanism in the development of AIDS that places a considerable emphasis on the potential of infected monocytes to serve as the reservoir in cases of persistent human immunodeficiency viral infections.[11] He suggested that monocytes possibly mediate the infection and the ultimate destruction of helper T cells. This hypothesis establishes a direct relationship between antigen presentation and HIV dissemination, accounting for the cytopathogenic effect and the exhaustion of the immune system commonly associated with the syndrome. This theory might account for the depletion of the helper T cell subsets based on their antigen specificity, and could explain the cellular immune response to the disease and offer mechanistic explanations for the progression from the initial to the final stage of AIDS.

The monocyte is capable, by directly or indirectly reacting to a variety of stimuli, to respond with a selective number of cellular products that affect early phases of the coagulation process. Although most studies have been carried out on isolated monocytes, the circulating monocyte appears to react to appropriate stimuli and, thus, acquires the capacity to initiate coagulation pathways. By utilizing plasma deficient and single coagulation proteins, other investigators have demonstrated that the major phenotype of the human monocyte expressing the procoagulant activity is the tissue factor.[12] This is a cellular lipid-protein complex expressed on the human monocyte surface following stimulation of the pathway by endotoxin and other activators.

The decrease in RT associated with monocyte activation may be a cost-effective marker for seroconversion and progression of disease because these values may return to normal secondary to decreased functional response of the monocyte to exogenous stimuli associated with immunodepression.

SUMMARY

The necessity of activated monocytes in the development of ARC and AIDS is receiving great emphasis. The generation of procoagulant activity by monocytes can be assessed by determining the RT. A hypercoagulable state is found when the values obtained from EARC, LARC, and AIDS patients are compared to healthy controls ($P < .05$). This simple, cost-effective test may be used to monitor the monocyte during the progression of disease. Further study is required. ■

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Abbreviations Used.

AIDS = Acquired immunodeficiency syndrome
ARC = AIDS-related complex
EARC = Early AIDS-related complex
LARC = Late AIDS-related complex
RT = Recalcification time
RTS = Recalcification time of the saline sample
RTE = Recalcification time of the endotoxin sample

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Drs. Ferraro and Spillert are affiliated with the Department of Surgery, Dr. Tecson-Tumang is affiliated with the Department of Medicine, and Dr. Lazaro is affiliated with the Department of Surgery and the Department of Anatomy, UMDNJ-New Jersey Medical School, Newark. The paper was submitted in December 1991 and accepted in February 1992. Address reprint requests to Dr. Ferraro, UMDNJ-New Jersey Medical School, Department of Surgery, MSB-G518, 185 South Orange Avenue, Newark, NJ 07103.

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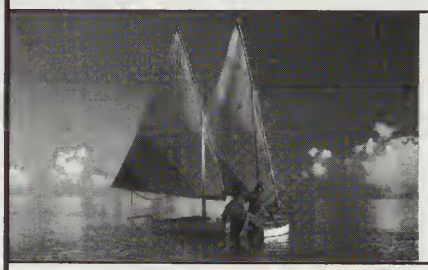
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HIV Infection in Kidney Transplant Recipients

Seymour Ribot, MD
Hossein H. Eslami, MD

Four HIV-infected patients received cadaver kidney transplants. A fifth kidney transplant patient acquired infection through a blood transfusion. The course and prognosis of these patients with HIV infection are described and a review of the literature is presented.

The dismal prognosis forecast for dialysis patients with human immunodeficiency virus (HIV) infection in earlier reports[1,2] contrasts with the more optimistic prognosis observed for asymptomatic patients in recent reports.[3,4] Although our policy had been to exclude HIV-infected kidney donors and recipients from renal transplantation, in the era prior to routine HIV testing of donors and recipients, four asymptomatic patients, retrospectively shown to have HIV infection, received kidney transplants. Three patients had a history of intravenous drug abuse and one patient had a history of homosexuality; all four patients presumably were HIV positive at the time of transplantation. A fifth patient, without known risk factors, acquired the HIV infection from a blood transfusion. We followed the course of these five HIV-infected transplant recipients. The history of these patients supports the contention that such patients have a less fulminant course than might be predicted.

PATIENTS AND METHOD

Between May 1984 and May 1987, 137 kidney transplants were performed at Newark Beth Israel Medical Center. Four of these patients were seropositive when routine HIV testing was instituted in July 1987. The fifth patient acquired HIV infection from a blood transfusion during surgical drainage of an allograft perinephric abscess. This patient had no other identifiable risk factors. All five patients were treated in an identical manner to those patients not HIV positive, receiving initial intravenous methylprednisone and maintenance immunosuppression with combinations of prednisone, azathioprine, and/or cyclosporine.

Serologic screening for HIV used the enzyme immunoassay (EIA). Positive results were confirmed by Western Blot testing.

RESULTS

The clinical course of our five patients is summarized in Table 1. Patient 1, without evidence of AIDS at the time of transplant but with a prior homosexual history, developed a clinical picture of AIDS and died 35 months later. The allograft was functioning satisfactorily at the time of death. The remaining four patients are alive, 39 to 107 months post-transplant. Three of four patients had a history of intravenous drug abuse. Patient 3 and patient 5 demonstrated chronic allograft rejection and were re-started on maintenance dialysis 52 and 107 months following transplantation (Table 1), respectively. Infectious complications in all four surviving patients have responded to conventional treatment, despite continued use of steroids, azathioprine, and/or cyclosporine.

DISCUSSION

The present report and review of the literature evaluates the natural history and prognosis of the asymptomatic HIV-positive transplant recipient and the patient who acquired HIV from an infected graft or transfusion. Table 2 summarizes the published data including our current observations.[5-16] Patients were classified as having primary HIV infection if the infection was present prior to transplantation, and patients were classified as having secondary HIV infection if the infection was acquired through an infected kidney donor or transfusion. Mortality data obtained by including our five patients with the reported patients (Table 2) indicated the following: Five of 11 patients died, 3 of them within the first year, with primary (pre-transplant) HIV infection,[11,12,16] and 4 of 20 patients died with secondary (acquired after transplant) HIV infection.[6,11,13,15] All 9 patients who died, whether HIV was primary or secondary, succumbed to

Table 1. *Summary of reported patients.*

Patient Kidney Source	Patient Age/Sex Race	Risk Factors	Months Allograft Function	Present Status	Status Graft	Infectious or AIDS-like Complications
1 *(CK)*	29/M Hispanic	IVDA	>77	S	F Cr = 1.6 mg/dl	HBS antigenemia, CMV infection, varicella, aphthous ulceration of the esophagus
2 *(RLD)*	34/M Black	HS	35*	D	—	Lymphoma lung, bacteremia, herpes simplex, CNS staph
3 *(CK)*	25/M Black	IVDA	52	S	DIAL 6/90	Proctitis
4 *(CK)*	44/F Black	IVDA	>39	S	F Cr = 2.4	Herpes zoster, oral moniliasis, acute pyelonephritis, *Monilia* esophagitis
5 *(CK)*	32/F White	T	107	S	DIAL 7/89	PCP, *Pseudomonas* infection dialysis access graft

CK: Cadaver kidney
RLD: Related living donor
IVDA: Intravenous drug abuser
HS: Homosexual
T: Transfusion
S: Survived
D: Died
F: Graft functioning
*: Graft functioning at time of death
DIAL: Restarted dialysis

AIDS; reports on 6 patients did not indicate whether HIV infection was primary or secondary.[8,11,16] Five deaths (25 percent) occurred within the first year in the 20 primary and secondary HIV-infected patients in whom survival was reported.[5,6,8,10-13,15,16] Only 2 patients survived with AIDS. Patient 5 (Table 1) recovered from *Pneumocystis carinii* pneumonia (PCP) and 1 patient recovered from miliary tuberculosis.[5]

Feinfeld reported one-year survival in 7 of 10 asymptomatic HIV-positive dialysis patients.[3] These patients correspond to the 11 primary HIV-infected patients where adequate followup data were available.[11,12,15,16] Eight of the 11 patients in this group survived more than one year. These observations suggest that one-year patient survival with kidney transplantation in primary HIV-infected dialysis patients may be comparable to one-year patient survival with dialysis.

The data from the era prior to routine HIV testing suggests that patients with secondary HIV infections do better than those primary infected patients. However, the natural history of all these patients, particularly those with secondary infection, demonstrates that some HIV-positive recipients may do well and may survive for prolonged periods despite opportunistic infections and despite the superimposed immunosuppressive therapy employed to prevent graft rejection.

In our current report, two of the five HIV-positive patients experienced chronic allograft rejection and had to be returned to hemodialysis (Table 1). The role of HIV and/or opportunistic infections in the rejection phenomenon is unclear.

The transmission of AIDS from a donor who initially tested negative by EIA was noted.[14] The donor had received 56 units of blood and blood products. Another transplant center found the same donor blood to be HIV positive by EIA using a different laboratory method (Genetics Systems, Seattle, Washington, and Abbott Laboratories, North Chicago, respectively). The HIV positivity in this case was confirmed later by Western Blot analysis. The donor heart, liver, and one kidney had been transplanted by the time the other teams had been notified. The kidney recipient was alive with asymptomatic HIV infection eight months post-transplant. Two other cases of secondary HIV infection in the literature were transmitted from one kidney donor.[5] Although one might intuitively feel that sibling kidney donors would provide the recipient with assurance of safety, there is one report in the literature of a transplant from an human leucocyte antigen (HLA) identical sibling in which the transplant resulted in recipient death from AIDS.[13] The donor HIV status later was verified retrospectively. In another report, infection resulting from a cadaver kidney allograft was transmitted from the recipient to her husband.[7]

Unlike heart or liver transplantation, the HIV-positive patient has an acceptable treatment alternative for renal failure with dialysis. In this regard, it should be pointed out that Ragni reported five HIV-positive hemophiliac patients who had undergone liver transplantation where no other alternative treatment was available.[17] The authors stated, "The potential for development of AIDS should not obscure the fact that most of them had a prolonged and meaningful life as a result of the trans-

plantation." Since survival with dialysis and transplantation are comparable, one must consider whether the quality of life advantage gained from kidney transplantation outweighs the allocation of scarce organs to patients with compromised prognosis. Data would support cadaver kidney transplantation for the rare asymptomatic HIV-positive patient where dialysis treatment no longer is feasible. ■

Table 2. ***Summary literature from references 5 to 16 and present report.***

	Primary		Secondary	
	Previous report	Present report	Previous report	Present report
Survival				
Living	3	3	15	1
Died	4	1	4	0
Not Specified	0	0	0	0
AIDS-like Illness				
Yes	4	1	5	1
No	3	3	14	0
Not Specified	0	0	0	0
**Function*				
Functioning	5	3	11	0
Rejected	1	1	2	1
Not Specified	0	0	5	0
Never Functioned	1	0	1	0
Total	7	4	19	1

Primary = Presumed HIV positive at time of transplant.
Secondary = Acquired HIV positive with or after transplant.
*Includes graft function at time of death.
Age range: 5 to 57 years, mean: 34.9 years.

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Dr. Ribot is clinical professor of medicine, UMDNJ, and director of the Division of Nephrology, and Dr. Eslami is clinical associate professor of surgery, and director, Division of Organ Transplantation, Newark Beth Israel Medical Center, Newark. Address reprint requests to Dr. Ribot, Newark Beth Israel Medical Center, 201 Lyons Avenue, Newark, NJ 07112.

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CLIA-88 Final Rule: Part 1

Kathleen Voldish, CLA (ASCP)

The final rules implementing the Clinical Laboratory Improvement Act (CLIA) of 1988 were published. Physicians will see their office laboratories fall under control of the federal government as of September 1, 1992. Physicians need to understand the regulations.

The final CLIA-88 regulations were published in the *Federal Register* on February 28, 1992, four years after being signed into law by former President Reagan. The effective date is September 1, 1992. Over 60,000 comments were received and reviewed by the Health Care Financing Administration (HCFA) after the May 1990 release of the proposed rules. Those rules aroused more controversy than any health care legislation in history. It is estimated that this regulation will cover 130,000 physician office laboratories. The Department of Health and Human Services (HHS) in Washington, DC accepted comments concerning technical and fee issues for 60 days following publication. However, these comments will not delay implementation nor is HHS obligated to respond to comments prior to the effective date. All other rules are final and comments will not be accepted (Table 1).

The complexity model includes three regulatory levels—waiver; moderate complexity (formerly level 1); and high complexity (formerly level 2). The waiver list has eight tests and the moderate complexity test level includes almost all commonly performed tests done in physician office laboratories (POLs).

Tests were categorized according to methodology and degree of risk to the patient. Estimates are that at least 75 percent of doctors will fall into the waiver or moderate complexity level (Table 2). HCFA will release a list matching specific instrumentation to each test prior to September 1, 1992.

Personnel and director requirements are greatly relaxed from those proposed in the May 1990 Standard. The waiver category does not have any personnel requirements other than submitting the name of the person directing or supervising the laboratory testing.

The director requirements for the moderate complexity level can be met easily by most physicians. The director must be a doctor of medicine or doctor of osteopathy, with at least one year of experience directing or supervising moderate complexity laboratory tests (the doctor's office laboratory), and be licensed to practice medicine in the state the laboratory is located. If the physician does not have one year of experience, 20 continuing medical education credit hours in laboratory practice must be obtained by August 2, 1993. Laboratory training acquired during a medical residency (such as hematology or oncology) can be substituted.

There are numerous other director qualification pathways but these are not relevant to physician office practices.

Moderate complexity laboratories also require a technical consultant such as a medical technologist with a baccalaureate degree; however, the physician director may fill this position as well. The function of clinical consultant can be filled by the physi-

Table 1. ***CLIA timetable.***

November 1991	Registration input survey forms
February 28, 1992	Final Standard published
Spring 1992	Registration and fee collection
September 1, 1992	Regulations take effect
January 1, 1994	Enrollment in proficiency testing

cian director also. The personnel performing the tests can be the doctor or a high school graduate (or equivalent) with documentation of training appropriate for the testing performed in the office (documented on-the-job training is acceptable). It is the director's responsibility to provide this training and to evaluate the employee's laboratory competence prior to that employee performing tests. The employee must understand the proper operation of the laboratory and documentation required under CLIA.

The director requirements for high complexity level testing adds a few additional requirements to those mentioned in the moderate complexity level. The physician must have two years' experience directing or supervising high complexity tests (in his office) or have had at least one year of laboratory training during medical residency. If a physician holds a current state license as a laboratory director this will qualify him to serve as a laboratory director in both a moderate or high complexity laboratory.

High complexity laboratories also require a technical supervisor. The Standard gives numerous qualification guidelines; for this position one needs to be a pathologist or specialized medical technologist with documented experience. However, a doctor with one year of training or experience in high complexity testing within the specialty and six months of experience within a subspecialty can qualify. The technical supervisor is not required to be on-site at all times but must be available to the laboratory as needed. The physician may act as the clinical consultant for his laboratory.

High complexity testing also requires a general supervisor. This individual may be a doctor with one year of training or experience in high complexity testing or an individual holding a minimum of an associate's degree

Table 2. ***CLIA-88 test level list.***

Certificate of Waiver

1. Dipstick or tablet reagent urinalysis (nonautomated) for the following: bilirubin, glucose, hemoglobin, ketone, leukocyte, nitrite, Ph, protein, specific gravity, and urobilinogen.
2. Fecal occult blood
3. Ovulation test—visual color comparison tests
4. Urine pregnancy test—visual color comparison tests
5. Erythrocyte sedimentation rate, nonautomated
6. Hemoglobin—copper sulfate, nonautomated
7. Spun hematocrit
8. Blood glucose (FDA—cleared home-use devices)

Moderate Complexity

1. Clinical cytogenetics
2. Histopathology
3. Histocompatibility
4. Cytology—no procedures
5. Bacteriology
   - (i) Primary culture inoculation
   - (ii) Urine culture/colony count kits
   - (iii) Microscopic evaluation of direct wet mount preparations
   - (iv) Isolation and presumptive identification of aerobic bacteria from throat or urine or cervical/urethral specimens
   - (v) Isolation and confirmatory identification of aerobic bacteria from throat or urine or cervical/urethral specimens
   - (vi) Gram stain
   - (vii) Dark-field examination for *Treponema pallidum*
   - (viii) Manual procedures with limited steps and with limited sample or reagent preparation
   - (ix) Manual screening devices for bacteriuria with limited steps and with limited sample or reagent preparation
   - (x) Automated procedures that do not require operator intervention during the analytic process
6. Mycobacteriology
   - (i) Direct acid-fast smear
7. Mycology
   - (i) Primary culture inoculation
   - (ii) Isolation and identification of yeast limited to *Candida albicans*
   - (iii) Identification procedures for *Candida albicans* (excluding semi-automated and semi-quantitative procedures)
   - (iv) Microscopic evaluation of direct wet mount preparations
   - (v) Tests using selective media for the presence or absence of dermatophytes
   - (vi) Microscopic evaluations of KOH preparations
   - (vii) Manual procedures with limited steps and with limited sample or reagent preparation
   - (viii) Automated procedures that do not require operator intervention during the analytic process
8. Parasitology
   - (i) Microscopic evaluation of pinworm preparations
   - (ii) Microscopic evaluation of direct wet mount preparation for the presence or absence of parasites
   - (iii) Manual screening with limited steps and with limited sample or reagent preparation
   - (iv) Culture devices indicating the presence or absence of *Trichomonas vaginalis*

Table 2. Continued

9. Virology
   - (i) Manual procedures with limited steps and with limited sample or reagent preparation
   - (ii) Automated procedures that do not require operator intervention during the analytic process

10. Immunology
   - (i) Manual procedures with limited steps and with limited sample or reagent preparation
   - (ii) Automated procedures that do not require operator intervention during the analytic process
   - (iii) Dark-field examinations for *Treponema pallidum*

11. Chemistry (Routine/Endocrinology/Toxicology)
   - (i) Automated procedures that do not require operator intervention during the analytic process
   - (ii) Automated blood gas analyses not requiring extensive operator intervention (such as instruments that have an automated process for calibration, sample intake, and flushing of sample lines)
   - (iii) Whole blood measurements using test stripmeters (excluding glucose monitoring devices cleared by the FDA specifically for home use)
   - (iv) Osmolality measurements
   - (v) Manual procedures limited steps and with limited sample or reagent preparation

12. Urinalysis
   - (i) Microscopic analysis of urinary sediment
   - (ii) Automated procedures that do not require operator intervention during the analytic process

13. Hematology
   - (i) Automated hematology procedures without differentials that do not require operator intervention during the analytic process
   - (ii) Automated hematology procedures with differentials that do not require operator intervention during the analytic process and that do not require an analyst to interpret a histogram or scattergram
   - (iii) Manual white blood cell differential counts when the analyst is not required to interpret any atypical cells
   - (iv) Manual hematological procedures with limited steps or with limited sample or reagent preparation
   - (v) Automated procedures that do not require operator intervention during the analytic process
   - (vi) Manual coagulation procedures with limited steps and with limited sample or reagent preparation

14. Immunohematology
   - (i) Manual or semiautomated procedures with limited steps and with limited sample or reagent preparation
   - (ii) Automated procedures that do not require operator intervention during the analytic process

15. Other
   - (i) Semen analysis (qualitative)
   - (ii) Occult blood on body fluid
   - (iii) Crystal analysis on joint fluid
   - (iv) Viscosity

Level II—Tests of High Complexity

All other tests

in a laboratory science or in medical laboratory technology and two years of laboratory training or experience in high complexity testing.

Testing personnel can be the doctor, the general supervisor, or an employee possessing a minimum of an associate's degree. Until September 1, 1997, an employee with a high school diploma (or equivalent) can continue to perform high complexity tests if he possesses the skill and knowledge necessary to perform these tests. If he plans to continue performing tests at this level, this individual will be required to have attained an associate's degree by September 1, 1997.

CERTIFICATES

Four types of certificates will be issued by HCFA. All certificates are valid for two years. If the practice has more than one location and testing is performed at all locations, a certificate must be obtained for each location. HCFA must be notified within 30 days of any changes in laboratory ownership, name, location, or director.

Certificate of waiver. These laboratories may only perform waived tests. Fee for this certificate is $100 for two years. If a test is added that is in the moderate complexity level, HCFA must be notified of this change before testing begins. The laboratory must follow the manufacturer's guidelines for testing. Waived laboratories are not required to be enrolled in proficiency testing. The laboratory may be subject to a routine inspection and the certificate would be renewable within nine months prior to the expiration date.

Registration certificate. This certificate will be issued to a previously unregulated moderate or high complexity laboratory upon submission of the application to HHS. The registration certificate is a precursor to the certificate described in the next section. It is similar to a learner's permit that is used to drive a car.

Detailed information relevant to testing and to personnel is required. The laboratory must comply with all the standards set forth in the regulation, must enroll in proficiency testing, and must treat proficiency testing samples in the same manner as it treats patient specimens. This certificate is not renewable. It is expected that the laboratory should be ready for inspection and pass inspection before the expiration date. If the laboratory passes the inspection, a certificate will be awarded. For laboratories doing less than five specialties and performing less than 25,000 tests a year, the fee would be $100. Laboratories performing up to 100,000 specialties and tests would pay $350. Laboratories performing over 100,000 tests a year would pay $600.

Certificate. If the registration certificate is a learner's permit, the certificate is the driver's license. The laboratory must meet all of the applicable requirements of the regulation for the level of testing performed and show competency in proficiency testing and pass a CLIA inspection. Fees will be determined by the number of specialties and the number of tests performed each year.

Certificate of accreditation. This certificate will be issued to laboratories that previously were regulated by a state or private organization that meet the standards of an accreditation program approved by HCFA. These programs must apply for "deemed status" under CLIA. Fees for this certificate will be determined by the issuing agency. The issuing agency will be responsible for inspections and monitoring the performance of the laboratories.

There is good news for previously unregulated private laboratories. If the laboratory fails to pass the inspection, the laboratory will be given a problem correction plan and adequate time to correct the problem, with no fines or sanctions being imposed. Part 2 of this three-part series will deal with inspections, sanctions, and proficiency testing. ■

Ms. Voldish is a physician office laboratory consultant. The article was submitted in April 1992 and accepted in May 1992. Address reprint requests to Ms. Voldish, 1150 Concord Drive, Haddonfield, NJ 08033.

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Description: Yohimbine is a 3a-15a-20B-17a-hydroxy Yohimbine-16a-carboxylic acid methyl ester. The alkaloid is found in Rubaceae and related trees. Also in Rauwolfia Serpentina (L) Benth. Yohimbine is an indolalkylamine alkaloid with chemical similarity to reserpine. It is a crystalline powder, odorless. Each compressed tablet contains (1/12 gr.) 5.4 mg of Yohimbine Hydrochloride.

Action: Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalmic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

Indications: Yocon® is indicated as a sympathicolytic and mydriatic. It may have activity as an aphrodisiac.

Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.[1,2] Also dizziness, headache, skin flushing reported when used orally.[1,3]

Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.[1,3,4] 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to ½ tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.[3]

How Supplied: Oral tablets of Yocon® 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.



References:

1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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The educational contents of each issue appear as scientific articles, based on research, original concepts relative to epidemiology of disease, and treatment methodology; case reports; review articles; clinical notes; state of the art reports; and special articles, that include evaluations, policy and position papers, and reviews of nonscientific subjects. Other topics include professional liability commentary; critical narration; medical history; pediatric briefs; nutrition update; and opinions. Editorials are prepared by the editor and by guest contributors on timely and relevant subjects. The Doctors' Notebook section contains organizational and administrative items from the Medical Society of New Jersey and from the community. Letters to the editor and book reviews are welcome and will be published as space permits.

The principal aim in the preparation of a contribution should be relevance to diagnosis and treatment and to the education of patients and professionals. Preference will be given to authors from New Jersey and to out-of-state lecturers submitting a suitable manuscript based on a presentation made to an audience in New Jersey.

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Submit two manuscripts that must be typewritten and double spaced on 8½" by 11" paper. Statistical methods used in articles should be identified.

The title page should include the full name, degrees, and affiliations of all authors, and the name and address of the author to whom reprint requests and correspondence should be sent.

The author should submit a 30-word abstract to be used at the beginning of the article.

Tables must be typewritten and double spaced on separate 8½" by 11" sheets, with a title and number. Symbols for units should be confined to column headings, and abbreviations should be kept to a minimum.

Illustrations should be professional quality, black-and-white glossy prints. The name of the author, figure number, and the top of the figure should be noted on a label attached to the back of each illustration. When photographs of patients are used, the subjects should not be identifiable or publication permission, signed by the subject or responsible person, must be included with the photograph. Material taken from other publications must give credit to the source.

Generic names should be used with proprietary names indicated parenthetically or as a footnote with the first use of the generic name. Proprietary names of devices should be indicated by the registration symbol—®.

The summary of the article should not exceed 250 words; it should contain essential facts.

References should not exceed 35 citations except in review articles, and should be cited consecutively by numbers in parentheses at the end of the sentence. The style of *NEW JERSEY MEDICINE* is that of *Index Medicus:*

1. Goldwyn RM: Subcutaneous mastectomy. *NJ MED* 74:1050-1052, 1977.

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Receipt of each manuscript will be acknowledged; the paper will be referred to the Editorial Board. Final decision is reserved for the editor. No direct contact between the reviewers and the authors will be permitted.

All communications should be sent to *NEW JERSEY MEDICINE,* MSNJ, 2 Princess Road, Lawrenceville, NJ 08648. □

DOCTORS' NOTEBOOK

TRUSTEES' MINUTES

A regular meeting of the Board of Trustees was held on May 2, 1992, at the Trump Taj Mahal Casino/Resort, Atlantic City. Detailed minutes are on file with the secretary of your county society. A summary of significant actions follows:

Reports. Received reports from Joseph A. Riggs, MD; and the University of Medicine and Dentistry of New Jersey.

Executive Director's Report.

1. MSNJ versus SBME—Biennial Licensing. Noted that this case will be argued before the State Supreme Court.

2. Implementation of New Medicare Claim Form. Noted that implementation of the new Medicare claim form has been postponed to June 30, 1992.

3. Legislation. Noted the following: the Legislature will attempt to override the governor's veto of S-413 (State Health Planning Board composition); bill delaying effective date of the State Health Plan (S-610; A-1144) and making it advisory is scheduled for release from the Senate Health Committee on May 4, 1992; and JUA surcharge bill passed the Senate.

MSNJ Auxiliary. Voted to cosponsor the seminar, "Legislative Seminar: Campaign '92—Exercise Your Franchise."

Council on Legislation.

1. Medicare Reimbursement. Voted to mail a one-page precis to member-physicians to help them educate patients about the resource-based relative value scale; the fact sheet could be duplicated and disseminated in physicians' offices.

2. Increased Physician Representation on State Advisory Boards. Approved the following recommendations:

That the Board of Trustees take action to initiate legislation that will provide for the appointment of physicians recommended by the Medical Society of New Jersey to the State Health Planning Board, the Health Care Administration Board, and the State Board of Medical Examiners; and

That the Council on Legislation receive an update within 90 days as to the current activities regarding the initiation of legislation.

3. Delayed Payment by Third-Party Payors. Approved the following:

That the Ad Hoc Committee of the Council on Legislation develop a legislative initiative that would impose the burden of proof upon an insurance carrier to explain a delay in the processing of claims beyond 21 days after receipt, and that the insurance company be required to pay interest for claims processed beyond that period of time.

Council on Mental Health. Adopted the following resolution for transmittal to the American Medical Association:

Resolved, that the basic insurance plan of the American Medical Association encompass coverage at parity with other medical coverages, to include major, severe, biologically correlated mental illnesses such as schizophrenia, schizo-affective illness, manic depressive illness, delusional depression, pervasive developmental disorder, and life-threatening conditions such as anorexia nervosa and suicide as diagnosed and treated by physicians with training and experience in the diagnosis, medical treatment, and medication of the above illnesses.

Committee on Conservation of Vision. Approved the following:

That the 1992 Eye Health Screening Program be held the week of September 21, 1992.

Committee on Physicians' Health. Approved the following:

That the Board of Trustees authorize the Physicians' Health Program staff to proceed with plans to hold a one-day smoking cessation conference.

Resolution on Statutory Interpretation on Limiting Charge Applicability. Adopted the following resolution and directed that it be referred to the American Medical Association:

Resolved, that the AMA bring an action for declaratory judgment against the federal government to establish that Medicare patients covered by Part B may freely contract with their physicians for services at fees beyond limited charges, provided reimbursement is not sought from Medicare.

Retiring Members of the Board. Expressed appreciation and commendation for a job well done to the following members: Joel S. Cherashore, MD; Douglas M. Costabile, MD; A. Ralph Kristeller, MD; John J. Pastore, MD; and Mr. Devang Shah. □

A reorganization meeting of the Board of Trustees was held on May 6, 1992, at the Trump Taj Mahal Casino/Resort in Atlantic City. Detailed minutes are on file with the secretary of your county society. A summary of significant actions follows.

Reorganization. Introduced the following newly elected officers: Joseph N. Micale, MD; Fred M. Palace, MD; Louis L. Keeler, MD; Bernard Robins; and Gerald H. Rozan, MD. Wel-

comed the newly elected Trustees: Mark T. Olesnicky, MD; G. Gerson Grodberg, MD; S. Manzoor Abidi, MD; and Churchill L. Blakely, MD. Also welcomed Judy Forster and George T. Hare, MD. Approved the practice of holding regular meetings of the Board of Trustees on the third Sunday of each month.

Referrals from the House of Delegates. Noted the following:

1. Resolution #1—Ethics of Self-Referral. Noted that the first resolved is a statement of the Medical Society of New Jersey (MSNJ) policy; will refer the second resolved to the American Medical Association (AMA) delegation for preparation of a similar resolution to be introduced to the AMA House of Delegates, and a letter will be sent to the State Board of Medical Examiners (SBME) to accomplish the aim of the third resolved:

Resolved, that MSNJ adopt the policy that a physician's referral to an off-site medical facility in which he has a financial interest is an ethical referral, as long as the patient is fully informed of the ownership/interest and alternate facilities (if available) are named; and be it further

Resolved, that the AMA delegation of MSNJ present a similar resolution to the AMA House of Delegates; and be it further

Resolved, that SBME be informed of MSNJ's position on this matter.

2. Resolution #18—Alternative to National Health Insurance. Referred to the Council on Medical Services for study and report:

Resolved, that MSNJ support the program proposed by the National Center for Policy Analysis; and be it further

Resolved, that said plan be recommended to the AMA for endorsement and support.

3. Resolution #22—Guidelines/Standards for Physician Advertising. Referred to the Judicial Council for guidelines and standards development, and implementation of second resolved will be delayed until review of the Judicial Council report:

Resolved, that MSNJ shall formulate guidelines and standards for advertising of medical/surgical practices so that any such advertisement will be honest and will act in the best interest of patients and the public; and be it further

Resolved, that after the guidelines and standards are formulated by MSNJ, they be forwarded to SBME for consideration and appropriate amendment.

4. Resolution #25—AMA's Renouncing of RBRVS. Referred to the AMA delegation for preparation of an appropriate resolution to be introduced to the AMA House of Delegates:

Resolved, that MSNJ instruct its AMA delegates to request the AMA to continue its efforts to refine, readjust, and eliminate the inequities of RBRVS, keeping in mind that it is a payment allocation schedule and not a fee schedule.

5. Resolution #31—Behavioral Offset Adjusted Basis Reduction. Referred to the AMA delegation for preparation of an appropriate resolution to be introduced to the AMA House of Delegates; also a letter will be sent to Health Care Financing Administration (HCFA) to implement the first and third resolveds.

Resolved, that MSNJ request that HCFA reconsider and increase the conversion factor; and be it further

Resolved, that the AMA be requested to urge HCFA to reconsider and increase the conversion factor consistent with statutory standards; and be it further

Resolved, that MSNJ petition HCFA to eliminate the behavorial offset adjustment.

6. Resolution #33—Limited-License Practitioners. Referred to the AMA delegation for an appropriate resolution to be introduced to the AMA House of Delegates:

Resolved, that MSNJ request the AMA to study the quality of care and economic issues related to delivery of health care by nonphysicians.

7. Resolution #35—Medicare Fees Under RBRVS. Referred to the Council on Public Relations for implementation and to the AMA delegation for preparation of a similar resolution to be introduced to the AMA House of Delegates:

Resolved, that MSNJ continually petition federal legislators to reverse the trend of diminished physician reimbursement that eventually will deny access of Medicare patients to medical care; and be it further

Resolved, that MSNJ work through the public media to inform the Medicare population of the actions of Congress and HCFA that will label Medicare beneficiaries as "second class patients" and, hence, limit or deny their access to the care that they need and deserve; and be it further

Resolved, that the AMA House of Delegates be requested to adopt a similar resolution.

8. Resolution #38E—Resolution To Revoke SBME Regulation N.J.A.C. 13:35-6.16—Professional Practice Structure Item Regulation 6.17. Will send a letter to SBME stating MSNJ's position:

Resolved, that MSNJ do all in its power to have SBME overturn *N.J.A.C. 13:35-6.16* and *6.17;* and be it further

Resolved, that if MSNJ is unable to get SBME to overturn this regulation, that MSNJ petition the Legislature to correct this unfair and inequitable regulation.

9. Resolution #40E—SBME *N.J.A.C. 13:35-6.16* and *6.17*. Referred the resolution to Mr. Maressa for study and report:

Resolved, that MSNJ actively oppose the new regulations of SBME (*N.J.A.C. 13:35-6.16* and *6.17*).

10. Resolution #2—Revision of Medical Waste Laws. Referred to the Council on Legislation and to the AMA delegation for preparation of an appropriate resolution to be introduced to the AMA House of Delegates:

Resolved, that MSNJ seek an amendment to state and federal medical

waste registration, tracking, and disposal laws exempting practitioners producing less than 200 pounds of medical waste per year; and be it further

Resolved, that MSNJ urge the AMA to seek a similar exemption under federal laws for all practitioners who generate less than 200 pounds of medical waste per year.

11. Resolution #9—AMA National Physician Credential Verification Service. Will send a letter to respective groups endorsing the service:

Resolved, that MSNJ endorse the AMA National Physician Credential Verification Service; and be it further

Resolved, that MSNJ encourage SBME, hospital credentialling committees, medical societies, and professional organizations to subscribe and utilize the AMA National Physician Credential Verification Service.

12. Resolution #10—Location of Annual Meetings. Referred to the Committee on Annual Meeting for consideration and report:

Resolved, that the Annual Meeting location of MSNJ be rotated among various regions of the state where feasible.

13. Resolution #11—Packaging of Pharmaceutical Samples. Will send a letter to the Pharmaceutical Manufacturers Association expressing concerns:

Resolved, that MSNJ encourage the pharmaceutical industry, as well as all health care companies, to be environmentally considerate when designing packaging for their products.

14. Resolution #15—NJ Pays Medicare Difference. Referred to the Committee on Medicaid for study and report:

Resolved, that MSNJ take appropriate action, with or without the participation of other organizations, to require Medicaid in the state of New Jersey to cover the difference between what Medicare allows and what it actually pays—including the deductible and coinsurance.

15. Resolution #17—Fees for the Disposal of Medical Waste. Will refer to the Council on Legislation for implementation:

Resolved, that MSNJ take appropriate action so that the medical waste registration fee is assessed to the practice rather than the individual office locations.

16. Substitute Resolution #19—Request for MSNJ Contribution to Dr. Lois J. Copeland's Legal Action Against the Federal Government. Approved a contribution of $1,000 by MSNJ to the American Health Legal Foundation to implement the first resolved; noted that a letter will be sent by Dr. Ryan to the MSNJ members requesting contributions to implement the second resolved; and referred the third resolved to the AMA delegation for preparation of a resolution to be introduced to the AMA House of Delegates:

Resolved, that the Board of Trustees consider expending a reasonable amount as a donation to assist Dr. Lois J. Copeland and her Medicare patients in their legal action against the federal government regarding the right to contract outside the Medicare program; and be it further

Resolved, that MSNJ actively seek tax-deductible donations to the legal fund regarding the right to contract outside the Medicare program from the membership, from other health care professionals, and from the general public; and be it further

Resolved, that the New Jersey delegation submit this issue to the AMA at the 1992 Annual Meeting.

17. Resolution #20—Request to MSNJ to Alternate Committee Meeting Dates and Places. Referred to the staff for study and report, and to the Committee on Long-Range Planning and Development for their consideration and assistance to the staff in the development of a comprehensive report on this subject:

Resolved, that the Board of Trustees consider alternating committee meeting dates and places to accommodate all committee members.

18. Resolution #21—HCFA Forms. Will send a letter to the New Jersey congressional delegation:

Resolved, that the Board of Trustees be instructed to initiate legislative action against HCFA in order to obtain injunctive and permanent relief from the onerous and expensive task of billing on HCFA forms without the ability to pass all the costs to the government or to the patient.

19. Resolution #23—Right of Physician To Pass Certain Federal and State Mandated Administrative Costs on to the "Consumer." Referred this matter to the Council on Legislation for implementation:

Resolved, that the Board of Trustees be instructed to initiate a lawsuit against HCFA and PBS, and any other federal, state, or local agency that interferes with the physician passing mandated costs to the ultimate consumer, seeking a permanent injunction to prevent such agencies from enacting penalties or in any other way interferring with said changes.

Resolved, that the Board of Trustees be instructed to seek correction legislation, addressed to HCFA, Congress, and any other federal, state, or local agency that interferes with the physician passing on mandated costs to the ultimate consumer, seeking permanent relief to prevent such agencies from enacting penalties or in any other way interferring with said changes.

20. Resolution #5—Unnecessary Insurance Regulation. Approved referral of Resolution #5 to the Council on Medical Services for report and recommendation, and to the AMA delegation for preparation of an appropriate resolution to be introduced to the AMA House of Delegates:

Resolved, that MSNJ work with managed care insurers, and state and local mandatory bodies to remove unnecessary burdensome, duplicative, and costly quality assurance regulations, and be it further

Resolved, that MSNJ forward a resolution to the AMA to foster removal of costly, unnecessary, burdensome, and duplicative regulations, and legislation that prevent spending the health care dollar on health care.

21. Recommendation #6—Closing Pediatric Beds. Will con-

vey MSNJ's concerns on this matter to appropriate state legislators:

Resolved, that MSNJ petition the commissioner of health and the governor to reconsider the hardships on individual communities that would result from the closing of their pediatric beds; and be it further

Resolved, that the New Jersey State Department of Health (NJDOH) be requested to work closely with MSNJ and NJHA on this matter; and be it further

Resolved, that NJDOH be requested to include MSNJ in decisions regarding all other aspects of the State Health Plan involving interaction between physicians and their patients.

22. Resolution #14—Medicare Reimbursement of New Physicians. Will refer to the Council on Legislation for appropriate action:

Resolved, that MSNJ petition the AMA to campaign to repeal the onerous congressional act that reduces reimbursement under Medicare for physicians during their first four years in practice.

23. Resolution #16—Children and Pre-existing Conditions. Will refer to the Council on Medical Services for study and report:

Resolved, that MSNJ take appropriate action with the New Jersey State commissioner of insurance to assure a governmental policy similar to those legislated in California that abolish restrictions on children's health coverage due to prior existing conditions.

24. Resolution #30—Assisting Surgeons. Will refer to the AMA delegation for preparation of an appropriate resolution:

Resolved, that MSNJ and the AMA petition Congress to immediately restore for reimbursement under Medicare the fees of assistant surgeons to the more equitable 25 percent of the surgeon's fee.

25. Resolution #34—Limiting Charges for Patients with Major Medical Insurance. Will carry out the actions called for in the resolution:

Resolved, that MSNJ promptly petition Congress and HCFA to remove the limiting charges for patients who carry third-party major medical supplemental insurance; and be it further

Resolved, that this resolution be forwarded to the AMA.

26. Resolution #41E—Organized Medicine's Role in Health Policy. Will refer to the AMA delegation for preparation of a resolution to be introduced to the AMA House of Delegates:

Resolved, that MSNJ adopt the following policy:

That there should be legally mandated formal physician organization in all areas of health policy development and implementation, including but not limited to negotiation of reimbursement, review of the quality and appropriateness of care, review of the appropriateness of fees, and establishment of overall budgetary predictability; and be it further

Resolved, that the AMA be requested to seek authorization to negotiate on behalf of its member physicians.

27. Resolution #3—(Tort Reform and Administrative Initiatives) and Resolution #7 (Tort Reform). Noted that this Substitute Resolution will remain with the Board of Trustees for consideration and action:

Resolved, that MSNJ and MIIX continue their joint efforts and consider the following areas of tort reform: (1) limitation of noneconomic damages; (2) shorten and make definitive the statute of limitations for adults and children; (3) that the prevailing party be awarded counsel fees and costs; (4) that the feasibility of periodic payments for future damages be considered; and (5) that MSNJ and MIIX study methods of alternative dispute resolution.

28. Substitute Resolution #4—Sale of Tobacco Products by Pharmacies. Will send a letter to the New Jersey Pharmaceutical Association expressing MSNJ's concern:

Resolved, that MSNJ reaffirm its support of the appropriate pharmaceutical organizations in their efforts to encourage the discontinuance of the sale of tobacco products by retail pharmacies.

29. Resolution #12—Community Violence. Referred to the Council on Public Relations for implementation:

Resolved, that MSNJ educate physicians in the recognition and management of domestic violence, including but not limited to child abuse, elder abuse, spousal abuse, and sexual abuse.

30. Resolution #27—Designation of Smoking Areas in Public Facilities. Will refer to the Council on Legislation for implementation and to the Council on Public Health for review and comment:

Resolved, that MSNJ seek legislation to provide that restaurants and public places be smokefree and at the proprietor's discretion provide smoking areas in lieu of current nonsmoking areas.

31. Substitute Resolution #28—Prohibition of Smoking in Public. Will send a letter to the governor and to the commissioner of health urging legislation be initiated and indicating MSNJ's support of the AMA policy calling for a smokefree society by the year 2000:

Resolved, that MSNJ encourage the government to prohibit smoking in public areas and workplaces to ensure the safety and health of nonsmokers, and that MSNJ's efforts in this regard be consistent with AMA policy calling for a smokefree society by the year 2000.

32. Resolution #36—State Health Plan. Will be referred to MSNJ's executive committee for discussion and action:

Resolved, that MSNJ initiate a campaign to encourage legislators to enact legislation to delay implementation of Phase 1 of the State Health Plan; and be it further

Resolved, that the Legislature be asked to subset phase 1 after one year to allow for a more orderly, democratic process to be used in addressing the phase 1 topics.

33. Resolution #37—Hospital Reimbursement. Will retain jurisdiction of this resolution and it will be monitored by Mr. Maressa:

Resolved, that MSNJ support legislative and/or regulatory initiatives that would create a free market model of hospital reimbursement.

34. Resolution #39E—Outdated Requirements for Premedical Education. Will be referred to the Committee on Medical Education and to the Committee on International Medical Graduates for study and report:

Resolved, that MSNJ petition New Jersey legislators to pass a resolution nullifying the 1915 law and giving SBME broader authority to evaluate the adequacy of premedical and medical education of the candidates applying for licensure to practice medicine in the state of New Jersey; and be it further

Resolved, that MSNJ support legislation to give SBME greater authority to determine if the deficiency of premedical education has been remedied at the graduate or postgraduate education level.

Current State Legislation. Approved all the positions recommended by the Council on Legislation on all legislation with the exception of: A-919 (State Health Planning Board Composition): voted to introduce a separate bill to encourage representatives of MSNJ be placed on the State Health Planning Board; A-1027 (AIDS Testing Required for Marriage License): changed to active support; and S-98 and A-1028 (AIDS Testing Combined with Testing for Venereal Disease): changed to active support.

New Business. Voted to allow a representative from Bill Clinton's campaign to present the candidate's health plan; will refer suggestion that retired physicians perform pro bono work to the Council on Medical Services; confirmed Dr. Ryan's intention that the second vice-president will attend meetings of SBME; and, referred the truncation of the Annual Meeting suggestion to the Committee on Annual Meeting for study and report. □

LEGISLATIVE BULLETIN

The following list presents the official position of the Medical Society of New Jersey (MSNJ) regarding bills currently in the Legislature. As further bills of medical interest are introduced, they will be considered by MSNJ and supplemental bulletins will be supplied, indicating MSNJ's position.

Senate/Assembly
(Active)

S-37–Rand (D). Requires the certification of dialysis technicians by the New Jersey Board of Nursing. **Active Support.**

S-149–Bassano (R). Permits Legislature to disapprove imposition of moratorium on issuance of certificates of need. **Active Support.**

S-150–Bassano (R). Eliminates $225 million annual cap on hospital capital construction costs for 1992 through 1994. **Active Support.**

S-151–Bassano (R). Restores exemption of physicians from certificate of need law. **Active Support.**

S-276–Ewing (R). Changes qualifications for commissioner of health and prescribes qualifications for deputy commissioner of health. **Active Opposition,** because the health care needs of our population require that a licensed physician serve in the position of commissioner of health. There are many qualified candidates. It is not advisable to dilute the requirements at a time when the nation and New Jersey, in particular, face a major public health crisis caused by drug addiction, AIDS, and environmental diseases.

S-291–Bassano (R). Requires certain seat height and seat belts on school buses; requires use of seat belts on school buses. **Active Support.**

S-350–Bassano (R). Provides for the licensure and regulation of physician assistants by the State Board of Medical Examiners. **Active Support.**

S-413–Schluter (R). Adds four legislators as members to State Health Planning Board. **Active Support.**

S-425–Codey (D). Changes standard of proof for disciplinary proceedings against physicians and podiatrists. **Active Support.**

S-450–Sinagra (R). Requires that the Health Care Administration Board include a representative of long-term health care facilities or services. **Support with Amendment,** including a member of MSNJ on the Board.

S-499–Bassano (R). Eliminates limitation on dispensing of drugs and medicines by physicians. **Active Support.**

S-599–Cardinale (R). Excludes certain medical malpractice insurance premiums from JUA debt assessments under the FAIR Act. **Active Support.**

S-610–Scott (R). Delays effective date of State Health Plan until January 1, 1993. **Active Support.**

S-611–Dorsey (R). Provides that chairman of Health Care Administration Board shall be appointed by the governor. **Active Support.**

S-635–Bassano (R). Permits psychologists to provide therapeutic services to their patients in hospitals under certain circumstances. **Active Support.**

A-175–Kavanaugh (R). Changes qualifications for commissioner of health and prescribes qualifications for deputy commissioner of health. **Active Opposition,** because the health care needs of our population require that a licensed physician serve in the position of commissioner of health. There are many qualified candidates. It is not advisable to dilute the requirements at a time when the nation and New Jersey, in particular, face a major public health crisis caused by drug addiction, AIDS, and environmental diseases.

A-178–Kavanaugh (R). Requires official state prescription for dispensing of certain drugs. **Active Opposition,** these systems have been attempted elsewhere and are not regulatory effective nor efficient.

A-217–Colburn (R). Permits Legislature to disapprove imposition of moratorium on issuance of certificates of need. **Active Support.**

A-283–Penn (R). Provides for use of certain health care facilities and appropriate privileges for licensed psychologists. **Support with Amendment,** permitting psychologists to provide therapeutic services to their patients in hospitals under certain

circumstances.

A-480–Bryant (D). Provides for referral of physical therapy patients to health care practitioners under certain circumstances. **Active Opposition,** this legislation is an incursion into the practice of medicine and would allow physical therapists to examine and treat patients without physician direction and would expose patients to delays in diagnosis, misdiagnosis, and iatrogenic injuries.

A-588–Impreveduto (D). Changes standard of proof for disciplinary proceedings against physicians and podiatrists. **Active Support.**

A-748–Shinn (R). Imposes limitations on annual DEP fees for medical waste generators. **Support with Amendment,** exempting generators that produce under 200 pounds of regulated medical waste.

A-844–Frelinghuysen (R). Eliminates $225 million annual cap on hospital capital construction costs for 1992 through 1994. **Active Support.**

A-906–Felice (R). Provides for the licensure and regulation of physician assistants by the State Board of Medical Examiners. **Active Support.**

A-919–Colburn (R). Adds four legislators as members to State Health Planning Board. **Active Support.**

A-923–Bush (D). Requires physicians who agree to treat Medicare patients to accept what the program pays without balance billing. **Active Opposition,** there is a successful voluntary effort to assure care to the poor. This legislation interferes with the constitutional rights of doctors and patients.

A-926–Bush (D). Requires physicians who agree to treat Medicare patients to accept what the program pays without balance billing for certain eligible patients. **Active Opposition,** unnecessarily favors wealthy seniors to the disadvantage of the middle class and the poor and is unfairly discriminatory against physicians.

A-934–Franks (R). Establishes the Office of Regulatory Services and revises the Administrative Procedure Act; appropriates $200,000. **Active Support.**

A-956–Roma (R). Eliminates joint and several liability; allows recovery of attorney fees and costs in negligence actions. **Active Support.**

A-1117–Franks (R). Excludes certain medical malpractice insurance premiums from JUA debt assessments under the FAIR Act. **Active Support.**

A-1144–Sosa (R). Delays effective date of State Health Plan until January 1, 1993. **Active Support.**

A-1150–Mikulak (R). Provides that chairman of Health Care Administration Board shall be appointed by the governor. **Active Support.**

Senate/Assembly
(Monitor)

S-81–Bubba (R). Revises eligibility standards and reduces copayments for certain pharmaceutical assistance programs.

S-99–Ewing (R). Requires posting of warnings on dangers of drinking during pregnancy.

S-101–Ewing (R). Reduces blood alcohol level at which a person is considered to be guilty of drunken driving, from 0.10 percent to 0.08 percent.

S-107–Cardinale (R). Requires public eating places to give notice of the use of MSG in the food.

S-113–Cardinale (R). The "AIDS Prevention Act of 1992."

S-141–Cowan (D). Designated the "Health Wellness Promotion Act."

S-146–Bassano (R). Classifies anabolic steroids as controlled dangerous substances.

S-148–Bassano (R). Requires pharmaceutical companies to provide rebates for products purchased under PAAD program.

S-157–Feldman (D). The "University of Medicine and Dentistry of New Jersey Flexibility Act of 1991."

S-170–Codey (D). Changes prescription forms to facilitate use of generic drugs.

S-175–Codey (D). Establishes the Senior Health Insurance Program and the legal representation program to assist Medicare beneficiaries in DCA, repeals P.L. 1987, c.59, and appropriates $250,000.

S-177–Zane (D). Revises no-fault insurance law, eliminates tort threshold, and permits reduced PIP coverage.

S-178–Zane (D). Amends the no-fault law to provide for mandatory PIP of $10,000 medical, with an option for unlimited medical.

S-194–Girgenti (D). Provides for establishment of health enterprise zones.

S-197–Connors (R). Establishes a "spend down" eligibility for pharmaceutical assistance based on high drug bills netted against income.

S-214–Bennett (R). Designated the "Emergency Medical Technician Training Fund Act."

S-243–Codey (D). Requires health insurers to provide benefits for treatment of mental illness and establishes minimum benefit levels.

S-257–Cafiero (R). Establishes a civil action for sexual abuse.

S-267–Rice (D). Requires Medicaid coverage for certain nonprescription medications, drugs, and vitamins.

S-274–Cafiero (R). Caps certificate of need application fee at $250 for entities that provide only EMT services.

S-280–Lesniak (D). Expands the scope of the "Pesticide Control Act of 1971."

S-284–Codey (D). Requires clinical laboratories to bill recipients of services directly.

S-328–Brown (R). Requires

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drivers of vehicles transporting students to school to complete a first-aid course.

S-330–Cardinale (R). Designated the "Health Wellness Certificate Plan Act."

S-331–Cardinale (R). Defines HIV infection as a venereal disease.

S-343–Connors (R). Prohibits DOH or any other entity from charging a fee to volunteer ambulance, first aid, and rescue squad personnel for EMT-A training and testing.

S-349–Sinagra (R). Restores certificate of need application fees to pre-July 1, 1991, levels.

S-356–Bassano (R). Establishes minimum emergency exit requirements, including a roof hatch, in all type I school buses.

S-363–Bennett (R). Requires DOH to prepare a booklet on prevention, detection, and treatment of breast cancer.

S-370–Bassano (R). Requires commissioner of health to contract with collection agencies for hospital bad debt collection services.

S-371–Bassano (R). Requires certain insurers, service corporations, and HMOs to offer basic health insurance plans to small business; establishes a reinsurance program.

S-372–Bassano (R). Establishes New Jersey Unemployment Health Insurance Plan for certain unemployed individuals.

S-374–Brown (R). Establishes an Office of the Ombudsman for Children and appropriates $250,000.

S-376–Brown (R). Establishes an Office of the Ombudsman for the Disabled.

S-387–Cowan (D). Makes certain requirements concerning downhill skiing.

S-390–Bassano (R). Establishes the New Jersey AIDS and Viral Disease Tissue Research Bank and appropriates $30,000.

S-398–Connors (R). Provides that a podiatrist is a physician within the scope of chapter 5 of Title 45 of the Revised Statutes.

S-408–Cafiero (R). Establishes emergency medical services for children program.

S-429–Cardinale (R). Requires retailers to label alcoholic beverages with a warning of the potential health hazards to unborn children.

S-461–Dimon (R). Reduces penalty for first violation of bike helmet law.

S-468–Adler (D). Requires offer of automobile medical expense benefits coverage up to $1,000,000 and that uninsured and underinsured motorist coverage limits be the same as liability limits.

S-476–Bassano (R). Allows a blood donor to direct his blood to a specific recipient.

S-477–Ewing (R). Extends eligibility for PAAD to persons disabled under certain federal programs.

S-478–Codey (D). Revises titles and duties of certain local health officers.

S-479–Codey (D). Establishes a youth suicide prevention program and appropriates $500,000.

S-481–Codey (D). Requires hospitals to notify Hospital Rate-Setting Commission of funds provided to the hospital's foundation or its subsidiaries.

S-517–Schluter (R). Prohibits boxing.

S-524–Cafiero (R). Permits minors to give consent for treatment for alcohol dependency.

S-551–Cardinale (R). Eliminates mandated benefits for treatment of alcoholism and requires group health insurers to offer such benefits.

S-558–Cardinale (R). Requires applicants for marriage licenses to obtain serological tests for certain genetic diseases.

S-592–Littell (R). Prohibits possession or consumption of alcoholic beverages on private property by persons under legal age.

S-596–Bennett (R). Requires radon testing in certain public buildings and public posting of the results.

S-597–Bennett (R). Extends requirement and immunity for reporting of drug abuse to any school employee.

S-622–Feldman (D). Designated the "Home Care Services Agency Licensure Act" and appropriates $400,000.

SR-22–Lipman (D). Urges FDA to lift ban on RU486 and approve its use in this country.

A-139–Arnone (R). The "Interstate Medical Waste Manifest Act."

A-148–Arnone (R). Eliminates age restrictions on blood donors.

A-172–Kavanaugh (R). Prohibits surrogate parenting agreements for consideration as a crime of the third degree.

A-203–Colburn (R). Requires hospitals to separately identify nursing costs in their budgets and bills to patients.

A-205–Colburn (R). Allows a blood donor to direct his blood to a specific recipient.

A-207–Colburn (R). Prohibits mail order sales of prescription eyeware.

A-208–Colburn (R). Changes membership of New Jersey Health Care Facilities Financing Authority.

A-209–Colburn (R). Prohibits the advertising of tobacco and related products on certain public properties.

A-210–Colburn (R). Creates a diagnosis related group study commission and appropriates $95,000.

A-211–Colburn (R). Provides assistance for development and implementation of a small business health insurance plan; appropriates $500,000.

A-212–Colburn (R). Requires that hospitals be reimbursed for the reasonable audited costs of autologous bone marrow transplant operations.

A-220–Catania (R). Concerns testing of persons arrested or convicted of certain crimes for AIDS.

A-227–Catania (R). Requires containers of hazardous substances sold to schools to be labelled in compliance with right-to-know.

A-228–Catania (R). Repeals certain references to anabolic steroids to reflect the recent addition to the controlled dangerous substance schedules; anabolic steroids subject to criminal provisions applicable to schedule III CDS.

A-229–Catania (R). Requires reports of incidents of suspected abuse or exploitation of the elderly or developmentally disabled.

A-234–Catania (R). Provides for the establishment of health enterprise zones.

A-269–Stuhltrager (R). Raises age for mandatory safety belt use and increases fine for violation of child restraint system law.

A-302–Roma (R). Disregards the Social Security COLA as income for eligibility in PAAD program.

A-359–Felice (R). Requires DOH to provide free vaccinations for serum hepatitis to emergency volunteers.

A-387–Heck (R). Expands and clarifies prescription drug container labeling requirements.

A-413–Pascrell (D). The "Comprehensive School Bus Safety Act."

A-420–Hudak (D). Establishes re-

quirements for number of certified school nurses in public schools.

A-439–Kelly (R). Excludes certain nursing services from unemployment compensation and temporary disability insurance contributions.

A-464–Bush (D). Provides for the detection and treatment of sickle cell anemia in newborns, appropriates $375,000.

A-489–Bryant (D). The "University of Medicine and Dentistry of New Jersey Flexibility Act of 1991."

A-515–Vandervalk (R). Directs Medicaid to establish community spouse resource allowance and income limits at highest levels permitted by federal law.

A-519–Vandervalk (R). Revises hospital collection procedures under the New Jersey Health Care Trust Fund.

A-536–Farragher (R). Permits board of education to test certain pupils for tuberculosis infection.

A-543–Frelinghuysen (R). Establishes 13-member State Health Benefits Program Advisory Committee; appropriates $50,000.

A-549–Frelinghuysen (R). Lowers limit on liability for hospitals to $25,000.

A-550–Frelinghuysen (R). Restores certificate of need application fees to pre-July 1, 1991, levels.

A-557–Rooney (R). Requires posting of notices warning about smoking tobacco products during pregnancy.

A-565–Rooney (R). Requires parental notification of an abortion performed on a minor.

A-585–Impreveduto (D). Establishes penalties under Title 45 of Revised Statutes for repeated failures by members of regulated professions to file completed applications with DEP; and requires boards to compile certain information.

A-589–Impreveduto (D). Concerns licensure of certain radiologic technologists.

A-608–Connors (R). Prohibits DOH or any other entity from charging a fee to volunteer ambulance, first aid, and rescue squad personnel for EMT-A training and testing.

A-611–Moran (R). Establishes spend down eligibility category for PAAD.

A-632–Martin (R). Permits boards of education to require steroid testing of participants in interscholastic athletics.

A-638–Martin (R). Requires the maintaining of only personal protection automobile insurance; eliminates mandatory liability.

A-639–Martin (R). Prohibits the discharge of certain substances into waters of this state and imposes penalties for violations.

A-663–Mikulak (R). Establishes the Office of Pediatric Emergency Medical Services.

A-671–Collins (R). Authorizes administrative or administrative consent orders issued by DEP to require health-impact studies in certain instances.

A-718–Kenny (D). Requires certain restaurants to provide nonsmoking areas.

A-724–Kenny (D). Mandates health insurance benefits for drug abuse treatment; creates Advisory Committee on Alcoholism and Drug Abuse Benefits.

A-732–Kenny (D). Restricts minors' access to tobacco vending machines.

A-757–Colburn (R). Requires certain insurers, service corporations and HMOs to offer basic health insurance plans to small businesses; establishes a reinsurance program.

A-768–Felice (R). Imposes certain additional conditions regarding the issuance of a certificate of need.

A-771–Felice (R). Requires DOH to provide free AZT treatment to emergency volunteers diagnosed with AIDS or HIV infection.

A-776–Felice (R). Provides that benefits under the "Pharmaceutical Assistance to the Aged and Disabled" program are last resource benefits.

A-778–Felice (R). Provides for annual increase in state supplementary payments to residents of residential health care facilities.

A-780–Felice (R). Supplemental appropriation of $1,781,000 in general funds and $1,670,000 in federal funds to increase Medicaid reimbursement to non-institutional providers of health services.

A-785–Bush (D). Requires AIDS testing for living donors of anatomical gifts.

A-786–Bush (D). Provides 1/12 of the eight cents surtax on cigarettes be deposited in the Cancer Research Fund and annually appropriated to the New Jersey Commission on Cancer Research.

A-790–Zangari (D). Permits worker's compensation claimant to choose doctor or chiropractor from an employer-provided list or petition to choose any doctor or chiropractor.

A-800–Heck (R). Requires boat operators involved in fatal boating accidents to be tested for alcohol or drug abuse.

A-857–LoBiondo (R). Permits rural hospitals to establish intermediate life-support programs.

A-865–Roma (R). Expands the scope of the "Pesticide Control Act of 1971."

A-866–Vandervalk (R). Provides for licensure of hospitals by DOH based on accreditation by Joint Commission on Accreditation of Health Care Organizations.

A-875–Bush (D). Designated the "Temporary Medical Leave Act."

A-879–Zecker (R). Exempts certified pedorthists from the provisions of the "Orthotist and Prosthetist Licensing Act."

A-880–Farragher (R). Designated the "Lyme Disease Prevention and Control Act."

A-881–Farragher (R). Imposes surcharge on drunken drivers to establish Spinal Cord and Head Injury Assistance Fund.

A-897–Stuhltrager (R). Requires persons charged with offenses to be tested for AIDS, sexually transmitted diseases, and hepatitis B in certain circumstances.

A-941–Doria (D). Requires hospitals to report annually to commissioner of health on monies received from private nonprofit entities.

A-970–Ogden (R). Requires health care facilities to notify first aid, ambulance, and rescue squads that they are transporting a patient who has AIDS or a contagious, infectious, or communicable disease.

A-978–Romano (D). Requires Medicaid coverage for certain nonprescription medications, drugs, and vitamins.

A-1020–Mikulak (R). Permits minors to give consent for treatment for alcohol dependency.

A-1026–Solomon (R). Increases fees for medical witnesses in worker's compensation cases.

A-1038–Martin (R). Mandates testing for lead toxicity as condition for certain school, nursery school, or child care attendance.

A-1040–W. Brown (D). Subjects motor vehicle driver and all passengers to a fine for seat belt violations as a primary action with certain exceptions.

A-1094–Rocco (R). The "Universi-

ty of Medicine and Dentistry of New Jersey Flexibility Act of 1992."

A-1104–Catania (R). Allows insurers to establish preferred provider arrangements with physicians, chiropractors, hospitals, and other health care providers.

A-1105–Catania (R). Clarifies that only chiropractors can determine need for chiropractic treatment in review of PIP benefits.

A-1106–Catania (R). Provides that chiropractic services must be provided by HMOs.

A-1123–Ogden (R). "Emergency Medical Technician Training Fund Act."

A-1124–Moran (R). Provides that a podiatrist is a physician within the scope of chapter 5 of Title 45 of the Revised Statutes.

A-1127–Impreveduto (D). Creates "New Jersey Self-Insurers Guaranty Association" to pay claims against insolvent employers who self-insure for worker's compensation.

A-1131–Penn (R). Permits application of certain tinting materials on motor vehicle windows and windshield for medical reasons.

A-1135–McEnroe (D). Designated the "Organ Transplant Fund Act."

A-1142–Martin (R). Allows for the use of nitrous oxide in food preparation.

A-1171–Gibson (R). Caps certificate of need application fee at $250 for entities that provide only EMT Services.

A-1173–Kelly (R). Establishes the Senior Health Insurance Program and the legal representation program to assist Medicare beneficiaries in DCA, repeals P.L.1987, c.59, and appropriates $250,000.

A-1200–Gaffney (R). Permits health service corporations to supply administrative services only. □

Barbara S. Golfetto

MSNJ AUXILIARY

On May 5, 1992, Marion Hughes Geib was inaugurated as the 66th president of the Medical Society of New Jersey Auxiliary (MSNJA). Her inaugural speech concentrated on three areas: the cost of medical care, access to medical care, and the quality of medical care. The following is an abridged version of Mrs. Geib's address:

Now, more than ever before, our Auxiliary will play a dynamic role in shaping the changes that will determine the future of medicine in this state and nation.

The Auxiliary is a powerhouse of talent, dedication, and good will. Together, we have the ability to take the helm, and rise with the tides, and buck the currents when necessary, to make sure the coming changes lead us all in the right direction.

The time is now, for Auxiliary members to address the three areas of change—one step at a time, one good idea at a time, and one person at a time.

1. Medical costs. The cost of medical care is high, and getting higher. The United States spends about $650 billion per year on health care—12 percent of our GNP. Medicare alone accounts for almost $130 billion of the federal budget. These astronomical costs raise the specter of nationalized medicine.

We need to look at the reasons why costs are so high in our U.S. health care system. About one-quarter of every dollar spent on medical care goes to cover malpractice liability defensive medicine and other administrative costs. In other words, a good portion of the money spent in the United States health care system goes to the system and not to health care.

This causes nothing less than a "crisis in spirit" for physicians across the country, who have built their practices on three priorities: patients, patients, and patients.

It is time we let the American public know the impediments to its health care system: impediments like a legal system gone awry, and government regulations gone amuck.

We are suffering under a malpractice insurance system that has spun out of control. During the last decade, physicians' professional liability premiums increased about 15 percent annually. So we need to press hard for liability and tort reform.

In addition, we are suffering under government regulations that have mushroomed beyond belief. Doctors and hospitals have become so flooded with paperwork, that what used to be a 15-person medical records office has swelled to a 50-person office.

We need to set the record straight, so the public knows where its medical dollar goes.

Above all, we need to press for tort reform, and to use our voting power. There are over 350,000 members of the AMA and its Auxiliary. When you add on other family members and employees, our voice grows even stronger—almost one million voters.

2. Access to care. The second area we must address is access to health care. MSNJ has proposed "Health Access New Jersey." It is patterned after the AMA's "Health Access America," but it is more specific to New Jersey issues.

As Auxiliary members, there are many practical ways we can publicize "Health Access New Jersey." We can write letters to editors, call lawmakers, work on legislative campaigns, inform news reporters, volunteer for telephone banks, make speeches to civic groups, inspire patients, and educate our fellow citizens. We all have a stake in this.

I am especially proud of our new "state capitol watchdog" group. Auxiliary volunteers will be the eyes and ears for MSNJ—attending sessions of the Legislature, getting to know our lawmakers, and keeping tabs on what goes on in our state capitol.

3. Quality of care. The third area we must address is the quality of our health care system. The United States is blessed with the best health care system in the world. In our hospitals, highly specialized (and even exotic)

procedures are routine. We do more heart, kidney, and other organ transplants than any other nation. We are the undisputed center of high-level research and advanced technology. We also lead in the graduate education and continuing education of physicians, nurses, and other trained experts. Our health system represents the very hallmark of quality.

As physicians and Auxiliary members, public education is central to our jobs. We must address the social pressures that influence patient behavior. We must teach resistance skills. We must educate everyone about the price we pay when we neglect preventive medicine.

According to the New Jersey State Department of Health, effective early treatment could reduce hospitalization costs by up to $650 million per year. Also, 10,000 of the 40,000 infant deaths in America could be prevented if we target high-risk neighborhoods, if we educate pregnant women about the dangers of smoking, drinking, and drug abuse, and if we simply encourage mothers to make better use of the health care resources that already are available.

As Auxiliary members, we must foster a sense of personal responsibility and encourage a "culture of character" (where people are more accountable for their actions). We need to reach out to everyone with our prevention message.

I am especially pleased to announce our new prevention project, "Responsibility on Water." We want to warn young people in New Jersey of the terrible dangers of mixing alcohol with water sports such as swimming, diving, surfing, skiing, and boating.



Marion H. Geib

Auxiliary actions. Prevention does not require money—it requires effort. After all, it does not cost anything to buckle up. It does not cost anything to abstain from smoking. It does not cost anything to stay out of the noonday sun. It does not cost anything to stop drinking during pregnancy. It does not cost anything to avoid high-risk sexual practices. It does not cost anything to remember to put on your bike helmet. It does not cost anything to take a healthy 20-minute walk each day. It does not cost anything to climb a flight of stairs instead of using the elevator. It does not cost anything to stay out of tanning parlors. It does not cost anything to cut back on junk snacks. It does not cost anything at all to designate a sober skipper.

It is hard work to educate people. But, it is a job that must be done, and it is a job that can be done . . . if we plant the seeds of prevention one step at a time, one good idea at a time, and one person at a time.

Perhaps this closing story sums up the attitude we all need:

A little boy and his grandfather were walking along the beach, and the old man watched the little boy pick up stranded starfish and throw them far back into the sea. The grandfather finally asked the little boy why he spent so much energy doing what seemed to be a waste of time. And the grandson explained that these stranded starfish would die if left exposed to the heat of the sun. The grandfather said, "There must be many thousands of miles of beach and many millions of starfish. So, how could your efforts make any real difference?" And the little boy looked down at the small starfish in his hand, and as he threw it back to the safety of the sea, he said with quiet confidence: "It makes a difference to this one."

And, that can serve as a lesson for us all.

It is up to us—the Auxiliary—take the lead on the medical issues we have been talking about—and it is up to us to get started today.

The learned religious leader, Hillel, once asked: "If not us, who? If not now, when?"

Today, at this meeting, we rededicate ourselves by saying: "Yes, the answer is us. And yes—the time is now." □

AMNJ REPORT

The Academy of Medicine of New Jersey's Annual Awards Dinner held on May 27, 1992, at the Chanticler in Short Hills was a major success. An enthusiastic gathering of 300 guests attended to honor our Award recipients and to help install our officers for the 1992-1993 year. Our Edward J. Ill Award recipient, Dr. Frederick B. Cohen of South Orange, and our Citizen's Award designee, Dr. Elizabeth Boggs of Hampton, were eloquent in their response. The Academy continued the tradition started at the 1991 Dinner of presenting lapel pins to past presidents in attendance at the evening affair.

The location of our 1993 event again will be the Chanticler and the date will be Wednesday, May 26, 1993. The Awards Committee, under the chairmanship of immediate past-president, Dr. Gerald Shapiro, is presently soliciting nominations for 1993.

The deadline for receiving nominations is September 18, 1992.

New AMNJ officers for 1992-1993 elected at the Annual Awards Dinner were President, George J. Hill, MD; President-Elect, John L. Krause, Jr, MD; 1st Vice-President, Palma Formica, MD; 2nd Vice-President, Richard Dixon, MD; Secretary, Connie Uy, MD; and Treasurer, Alan Lippman, MD.

The Academy's staff is preparing the Annual Calendar for 1992-1993. The Calendar includes many items of interest including CME activities for the upcoming academic year, a list of available roving symposia topics, an application to participate in our Speakers Bureau, and a list of affiliated specialty societies and their presidents. In addition, the 1992-1993 issue includes an up-to-date version of our constitution and bylaws.

We are pleased to report that as of July 1, 1992, the Academy added the New Jersey Chapter of the American College of Physicians (ACP) to its list of specialty societies receiving management services. ACP with approximately 3,000 New Jersey members, is the 40th group to be added to the Academy's growing list. ACP, the nation's largest medical specialty society, works to uphold health care standards through activities in continuing education, health policy analysis, quality assurance, and medical technology assessment. Its national membership includes more than 70,000 primary care physicians and specialists in the various branches of internal medicine. Dr. Mary Herald of Overlook Hospital is the governor of the New Jersey chapter. ☐ George J. Hill, MD, President

UMDNJ NOTES

UMDNJ dedicates Doctors Office Center. UMDNJ dedicated its new $55 million UMDNJ-New Jersey Medical School Doctors Office Center. The eight-story, 154,000 square foot center is home to the UMDNJ-New Jersey Medical School's faculty practice, which includes more than 250 physicians in dozens of medical specialties. The faculty practice of the UMDNJ-New Jersey Dental School is scheduled to move into the center later this year.

A full-service ambulatory care facility, the center comprises a number of nationally recognized specialty programs, including: The Ophthalmology Center, associated with the Eye Institute of New Jersey; The Center for Fertility and Reproductive Medicine; The Allergy/Immunology Center; The Pain Management Center; The Centers for Human Genetics and Prenatal Diagnosis; The Liver Center; and The Multiple Sclerosis Comprehensive Care Program.

The center also features a state-of-the-art same-day surgery suite, a comprehensive imaging center and a fully equipped center for rehabilitation services.

Pact with Public Health Service. The UMDNJ-New Jersey Dental School and the U.S. Public Health Service have agreed to form an oral health care network—believed to be the first of its kind nationally—to develop community dental clinics for the state's underserved populations.

The two organizations signed an affiliation agreement to form the statewide network at UMDNJ's Newark campus. The agreement will significantly broaden the scope of the dental school's service far beyond its Newark campus.

Dr. William R. Cinotti, associate dean for interdisciplinary and extramural programs at the dental school, initiated the network concept.

Lead screening begins for southern New Jersey youngsters. Up to 6,000 suburban children, aged one to six are being screened for deadly lead poisoning at three Camden County clinics, starting this month. The screenings will be given to 4,000 to 6,000 children a year under the auspices of UMDNJ-School of Osteopathic Medicine, Stratford. A $12,000 grant from the MetPath Foundation of Teterboro to the Foundation of UMDNJ will help implement the program. In addition, MetPath, Inc., one of the nation's leading clinical diagnostic laboratories, will provide technical assistance in support of the lead screening project.

Once thought to be an inner-city problem, children in most areas of New Jersey now are believed to be at risk for lead poisoning. The tests will follow new standards issued by the federal Centers for Disease Control (CDC) in Atlanta, Georgia. Under the new CDC guidelines, lead levels will be considered dangerous if they measure 10 micrograms per deciliter of blood or higher. A level of 25 micrograms per deciliter formerly was deemed safe.

Nissan boosts EOHSI environmental program. Nissan Motor Corporation of Gardena, California, presented $10,000 to the Environmental and Occupational Health Sciences Institute (EOHSI), Piscataway, for its children's environmental health education curriculum. EOHSI is jointly sponsored by UMDNJ and Rutgers University.

The curriculum was developed by EOHSI's Division of Public Education and Risk Communication. It includes lessons on the importance of clean air and water and the benefits of recycling.

Pilot testing of the school curricula has shown that educators are interested in new resources and training to educate students about environmental and occupational health concerns. The Nissan grant will be used for the development of print video materials in the middle school curriculum. ☐ Stanley S. Bergen, Jr, MD

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Wednesday, September 9, 1992 3:00-5:00 PM

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Moderator: Bernard L. Segal, M.D.

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- *Case Presentations–Marc Tecce, M.D.*
- *Panel Discussion–Michael Feldman, M.D., Terry Langer, M.D., Marvin Rosner, D.O.*
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CONTINUING EDUCATION

DIABETES

October

1 **Diabetic Retinopathy**
8-9 A.M.—VA OP Clinic, Brick
(AMNJ and NJDOH)

9 **Diabetic Retinopathy**
8:15-9:15 A.M.—Rutgers Student Health Services, New Brunswick
(AMNJ and NJDOH)

13 **Diabetes-Related Cardiovascular Disease**
12 Noon-1 P.M.—The Mountainside Hospital, Montclair
(AMNJ and NJDOH)

15 **Prevention of Lower Extremity Amputations**
8-9 A.M.—VA OP Clinic, Brick
(AMNJ and NJDOH)

16 **Diabetes-Related Cardiovascular Disease**
8:15-9:15 A.M.—Rutgers Student Health Service, New Brunswick
(AMNJ and NJDOH)

INFECTIOUS DISEASE

September

9 **Diagnosis and Treatment of AIDS**
12 Noon-1 P.M.—Southern Ocean County Hospital, Manahawkin
(NJDOH and AMNJ)

10 **Integrating TB Management into Care of the HIV-Infected Patient**
10:30-11:30 A.M.—Overlook Hospital, Summit
(NJDOH and AMNJ)

15 **Integrating TB Management into Care of the HIV-Infected Patient**
12 Noon-1 P.M.—The Hospital Center at Orange, Orange
(NJDOH and AMNJ)

16 **Identification and Management of Asymptomatic HIV Infection**
10-11 A.M.—The Hospital Center at Orange, Orange
(NJDOH and AMNJ)

21 **Diagnosis and Treatment of AIDS**
1-2 P.M.—New Lisbon Developmental Center, New Lisbon
(AMNJ and NJDOH)

23 **Identification and Management of Asymptomatic HIV Infection**
12 Noon-1 P.M.—Southern Ocean County Hospital, Manahawkin
(NJDOH and AMNJ)

28 **Infection Control in the HIV Era**
12 Noon-1 P.M.—Rancocas Hospital, Willingboro
(NJDOH and AMNJ)

30 **Infection Control in HIV Era**
12 Noon-1 P.M.—Southern Ocean County Hospital, Manahawkin
(NJDOH and AMNJ)

October

1 **Integrating TB Management into Care of the HIV-Infected Patient**
8:30-9:30 A.M.—Community Health Care of New Jersey, Orange
(NJDOH and AMNJ)

2 **Identification and Management of Asymptomatic HIV Infection**
8:15-9:15 A.M.—Rutgers Student Health Service, New Brunswick
(NJDOH and AMNJ)

7 **Infection Control in the HIV Era**
12:30-1:30 P.M.—Kessler Institute for Rehabilitation, West Orange
(NJDOH and AMNJ)

14 **Identification and Management of Asymptomatic HIV Infection**
9-10 A.M.—Riverview Medical Center, Red Bank
(NJDOH and AMNJ)

14 **Infection Control in the HIV Era**
10-11 A.M.—The Hospital Center at Orange, Orange
(NJDOH and AMNJ)

14 **Infection Control in the HIV Era**
11 A.M.-12 Noon—Kessler Memorial Hospital, Hammonton
(AMNJ and NJDOH)

15 **Identification and Management of Asymptomatic HIV Infection**
9-10 A.M.—Dover General Hospital, Dover
(AMNJ and NJDOH)

16 **Integrating TB Management into Care of the HIV-Infected Patient**
10-11 A.M.—Marlboro Psychiatric Hospital, Marlboro
(NJDOH and AMNJ)

16 **Identification and Management of the HIV-Inderminant Infant**
12 Noon-1 P.M.—Southern Ocean County Hospital, Manahawkin
(NJDOH and AMNJ)

21 **Multiple Resistant TB**
12:15-1:30 P.M.—John Fitch Plaza, Trenton
(NJDOH and AMNJ)

21 **Infection Control in HIV Era**
10:30-11:30 A.M.—Overlook Hospital, Summit
(AMNJ and NJDOH)

22 **Integrating TB Management into Care of the HIV-Infected Patient**
12 Noon-1 P.M.—Rancocas Hospital, Willingboro
(NJDOH and AMNJ)

28 **Epidemiology and Current Trends in HIV Infections and AIDS**
1:30-2:30 P.M.—Greystone Park Psychiatric Hospital, Greystone Park
(AMNJ and NJDOH)

Hahnemann University

Department of Medicine Grand Rounds
Wednesdays 8:30 a.m.-9:30 a.m.

SEPTEMBER 1992

September 9, 1992
THE PATIENT WITH HEART DISEASE: THE IMPORTANCE OF THE INITIAL EXAMINATION
J. Willis Hurst, M.D.
Professor of Medicine
Department of Medicine (Cardiology)
Emory University
Atlanta, GA

September 16, 1992
CRITICAL CARE OF THE IMMUNOSUPPRESSED PATIENT
Harold L. Paz, M.D.
Assistant Professor of Medicine & Anesthesiology
Director, Medical Intensive Care Units
Hahnemann University

September 23, 1992
RACIAL DIFFERENCES IN CORONARY ARTERY DISEASE AND HYPERTENSION
Charles K. Francis, M.D.
Professor of Clinical Medicine
Columbia University College of Physicians and Surgeons
Chairman, Department of Medicine
Harlem Hospital Center, NY, NY

September 30, 1992
HEADLINE NEWS FOR THE INTERNIST: TOPICS THAT WILL INFLUENCE YOUR CAREER
David S. Kountz, M.D.
Assistant Professor of Medicine
Codirector, Medical Residency Program
Department of Medicine
Hahnemann University

OCTOBER 1992

October 7, 1992
Yom Kippur—No Grand Rounds

October 14, 1992
MECHANISMS OF GUT PEPTIDES IN NEUROENDOCRINE DISORDERS
Thomas O'Dorisio, M.D.
Professor of Medicine and Physiology
Director, Division of Endocrinology
Ohio State University
Columbus, Ohio

October 21, 1992
PULMONARY DISEASE
Jay N. Nadel, M.D.
Professor of Medicine and Physiology
Chief, Section of Pulmonary Diseases
Director, Multidisciplinary Training Program in Lung Diseases, C.V.R.I.
University of California/San Francisco
San Francisco, CA

October 28, 1992
NEW APPROACHES TO IDENTIFICATION OF MYOCARDIAL ISCHEMIA
Leonard S. Dreifus, M.D.
Professor of Medicine
Director, Division of Cardiology
Hahnemann University
J. Yasha Kresh, Ph.D.
Professor and Director
Department of Cardiothoracic Surgery and Professor of Medicine
Director of Cardiovascular Biophysics and Computing
Division of Cardiology
Hahnemann University
Amir Pelleg, Ph.D.
Associate Professor
Division of Cardiology
Hahnemann University

NOVEMBER 1992

November 4, 1992
HYPOTHYROIDISM: PATHOGENESIS AND IMMUNE MECHANISMS
E. Chester Ridgway, III, M.D.
Professor of Medicine
Head, Division of Endocrinology
University of Colorado Health Science Center
Denver, CO

November 11, 1992
CLINICAL REVIEW OF MORTALITY STUDIES IN CONGESTIVE HEART FAILURE
Gary S. Francis, M.D.
Professor of Medicine
Cardiovascular Division
University of Minnesota School of Medicine
Minneapolis, MN

November 18, 1992
MECHANISMS AND NEW STRATEGIES FOR TREATING AUTOIMMUNE DISEASES
David Wofsy, M.D.
Associate Professor of Medicine
Chief, Rheumatology Division
San Francisco VA Medical Center
San Francisco, CA

November 25, 1992
Thanksgiving Holiday—No Grand Rounds

DECEMBER 1992

December 2, 1992
ASPIRIN, M.S.G., BISULFITES AND ASTHMA
Ronald Simon, M.D.
Associate Clinical Professor of Medicine & Pediatrics
University of California/San Diego School of Medicine
Head, Division of Allergy & Clinical Immunology
Scripps Clinic and Research Foundation
La Jolla, CA

December 9, 1992
CHOLESTEROL REDUCTION IN PRIMARY PREVENTION: UNANSWERED QUESTIONS AND UNANSWERED ANSWERS
Jeremy Swan, M.D., Ph.D.
Professor of Medicine
UCLA School of Medicine
Los Angeles, CA

December 16, 1992
BREAST CANCER: DIAGNOSIS AND TREATMENT
Jeffrey Brodsky, M.D.
Assistant Professor of Surgery
Division of Surgical Oncology
Department of Surgery
Hahnemann University
Pamela Crilley, D.O.
Assistant Professor of Neoplastic Diseases
Department of Neoplastic Diseases
Hahnemann University

December 23, 1992
Christmas Holidays—No Grand Rounds

Hahnemann University Department of Medicine
Wednesday Medical Seminar Series
8:30 a.m.—3:30 p.m.

September 16, 1992
CRITICAL CARE OF THE IMMUNOSUPPRESSED PATIENT
Course Director: Harold L. Paz, M.D.

October 21, 1992
PULMONARY MEDICINE
Course Director: Edward S. Schulman, M.D.
Guest Faculty: Jay A. Nadal, M.D.

November 18, 1992
MECHANISMS AND STRATEGIES FOR TREATING AUTOIMMUNE DISEASES
Course Director: Richard L. Spielvogel, M.D.
Guest Faculty: Alice Gottlieb, M.D.
Richard P. MacDermott, M.D.
David Wofsy, M.D.

December 2, 1992
ASTHMA
Course Directors: David M. Lang, M.D.
Guest Faculty: Ronald Simon, M.D.

December 16, 1992
BREAST CANCER: DIAGNOSIS AND TREATMENT
Course Codirectors: Jeffrey Brodsky, M.D.
Pamela Crilley, D.O.
Guest Faculty: To be announced

Seminar Director:

Allan B. Schwartz, M.D.
Professor and Vice Chairman of Medicine
Director, Continuing Medical Education for the Department of Medicine

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MEDICINE

September

3 **Tumor Board Conference**
10 12:15 P.M.—Mercer Medical
17 Center, Trenton
24 *(AMNJ)*

11 *Grand Rounds*
18 9-10 A.M.—St. Francis Medical Center, Trenton
(St. Francis Medical Center)

11- **3rd Annual Cardiology**
13 **Meeting**
Marriott's Seaview Golf Resort, Absecon
(NJ Chapter, American College of Cardiology)

14 **Neurosurgical Emergencies**
7-8 P.M.—Wallkill Valley General Hospital, Sussex
(AMNJ)

15 **Anesthesiology Membership Meeting**
All day—Ramada Inn, Clark
(NJ State Society of Anesthesiologists)

15 **Financing Graduate Medical Education**
12:15-1:30 P.M.—John Fitch Plaza, Trenton
(AMNJ)

22 **Chronic Pain Management and Issues Related to Iatrogenic Addiction**
12 Noon-1 P.M.—West Jersey Hospital, Voorhees
(AMNJ)

23 **New Practice Program**
8:45 A.M.-4 P.M.—MSNJ headquarters, Lawrenceville
(MIIX and AMNJ)

25 **Access to Health Care**
9 A.M.-4 P.M.—Holiday Inn, Jamesburg
(AMNJ and Perinatal Association of NJ)

30 **Clinical Aspects of Prosthesis in Dental Medicine**
1:30-2:30 P.M.—Greystone Park Psychiatric Hospital, Greystone Park
(AMNJ)

October

2 **Grand Rounds**
16 9-10 A.M.—St. Francis Medical
30 Center, Trenton
(St. Francis Medical Center)

6 **Common Dermatoses**
12 Noon-1 P.M.—The Hospital Center at Orange, Orange
(AMNJ)

8 **Venous Ultrasound**
7:30-9:30 P.M.—JFK Medical Center, Edison
(NJ Institute of Ultrasound)

8- **Critical Care Medicine**
10 **Scientific Symposium**
Sheraton Society Hill, Philadelphia
(NJ Society of Critical Care Medicine)

9 **Semi-Annual Obstetrics/Gynecology Meeting**
All day—Holiday Inn, Jamesburg
(AMNJ)

13 **General Membership Meeting**
6 P.M.—Schering Corporation, Kenilworth
(Dermatological Society of NJ)

14 **Medical Problems in the Elderly**
1-2 P.M.—VA Medical Center, Lyons
(AMNJ)

17 **New Practice Program**
8:45 A.M.-4 P.M.—MSNJ headquarters, Lawrenceville
(MIIX and AMNJ)

20 **New View of Distal Renal Tubular Acidosis**
9 A.M.—Overlook Hospital, Summit
(AMNJ and Nephrology Society of NJ)

22 **Scientific Meeting**
6:30-9:30 P.M.—The Manor, West Orange
(Head and Neck Oncology Section, AMNJ)

23- **17th Annual Orthopedic**
24 **Society Symposium**
Somerset Marriott Hotel, Somerset
(NJ Orthopedic Society)

28 **Medical History Society of New Jersey**
3:30-9 P.M.—Nassau Club, Princeton
(AMNJ)

PSYCHIATRY

September

2 **Psychiatric Case Conference**
1:30-2:30 P.M.—Greystone Park Psychiatric Hospital, Greystone Park
(AMNJ)

9 **Introduction to Neuropsychology**
1:30-2:30 P.M.—Greystone Park Psychiatric Hospital, Greystone Park
(AMNJ)

16 **Journal Club**
2:30-4 P.M.—Greystone Park Psychiatric Hospital, Greystone Park
(AMNJ)

17 **Antidepressant Medication in Psychoanalytic Therapy**
8-10 P.M.—Hackensack Medical Center, Hackensack
(NJ Psychoanalytic Society and AMNJ)

October

7 **Psychiatric Case Conference**
1:30-2:30 P.M.—Greystone Park Psychiatric Hospital, Greystone Park
(AMNJ)

15 **Monthly Meeting**
6 P.M.—Hackensack Medical Center, Hackensack
(NJ Psychoanalytic Society and AMNJ)

16 **Journal Club**
21 2:30-4 P.M.—Greystone Park Psychiatric Hospital, Greystone Park
(AMNJ)

23 **Mental Disorders in the Elderly**
8:15 A.M.-4 P.M.—The Hyatt New Brunswick
(AMNJ)

RADIOLOGY

September

17 **Update on Pancreatic Imaging**
7:30-10 P.M.—Saint Barnabas Medical Center, Livingston
(AMNJ)

October

2 **Visiting Professor Lecture**
1:30-5 P.M.—Saint Barnabas Medical Center, Livingston
(AMNJ)

15 **Advances and Controversies in Musculoskeletal MRI**
7:30-10 P.M.—Saint Barnabas Medical Center, Livingston
(AMNJ) □

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IN MEMORIAM

JOSEPH A. ALCARO

An ear, nose, and throat and allergy specialist, Joseph A. Alcaro, MD, died on April 17, 1992, at the grand age of 82. Dr. Alcaro was born on January 4, 1910, in New York City. He attended the University of Bologna, Italy, and was awarded a medical degree in 1937. He received his New Jersey medical license in 1940. Dr. Alcaro practiced in Morristown and in Gettysburg, Pennsylvania. He was affiliated with New York Eye and Ear Infirmary; Dover General Hospital and Medical Center; Morristown Memorial Hospital; and Gettysburg Hospital. Dr. Alcaro was a member of our Morris County component.

JOSEPH D. BARBELLA

On April 19, 1992, Joseph Daniel Barbella, MD, passed away. He was 80 years old. Dr. Barbella was born in Newark on February 10, 1912. He was awarded a medical degree from Hahnemann Medical College, Philadelphia, in 1938. The following year, Dr. Barbella received his New Jersey medical license. He completed a residency at French Hospital-Bellevue Hospital, New York, in 1941. Dr. Barbella was a general practitioner and anesthesiologist in Newark, and was attending at the Hospital for Crippled Children, Newark. He was a member of our Essex County component and of the American Medical Association. He resided in Newark and moved to Chicago, Illinois, in 1986. Dr. Barbella was a United States Navy veteran, serving in the Medical Corps during World War II.

IRVING P. BORSHER

At the grand age of 86, Irving Philip Borsher, MD, passed away on April 10, 1992. He was born in New York City, on April 1, 1906, and resided in Bloomfield, Newark, and Upper Montclair. Dr. Borsher was awarded a medical degree from New York University School of Medicine, New York, in 1930. After Dr. Borsher completed an internship at Bronx Hospital, New York, and a residency at Presbyterian Hospital, Newark, he received his New Jersey medical license in 1934. Dr. Borsher, an internist, practiced in Bloomfield until 1943, when he served with the United States Army Medical Corps. After his military service, Dr. Borsher practiced in Newark. He was attending at Presbyterian Hospital, Newark; executive vice-president and medical director at New Jersey Blue Shield for seven years; member of our Essex County component, of the American Medical Association, and of the Academy of Medicine of New Jersey; fellow of the American College of Chest Physicians; and diplomate of the American Board of Internal Medicine.

VICTOR E. BURN

We regret to announce the death of Victor Emil Burn, MD. Dr. Burn passed away on April 3, 1992. He was 89 years old. Dr. Burn was born in Canada on January 7, 1903. Dr. Burn attended the University of Toronto, Canada, and was awarded a medical degree in 1932. He received his New Jersey medical

license in 1934. A resident of Newton, Dr. Burn also maintained a practice in Newton. He was a surgeon affiliated with Newton Memorial Hospital, Morristown Memorial Hospital, and the former Franklin Hospital. Dr. Burn was a member of our Sussex County component and of the American Medical Association, and a fellow of the American College of Surgeons.

JOSEPH R. BURNS

Eighty-one-year-old Joseph Robert Burns, MD, of Trenton, died on April 18, 1992. Dr. Burns was born in Trenton, on July 31, 1910. He graduated from Temple University School of Medicine, Philadelphia, in 1936. The following year, Dr. Burns received his New Jersey medical license. He completed an internship at Mercer Medical Center, Trenton, and a residency at Bronx Eye and Ear Infirmary, New York. Dr. Burns was chief of otolaryngology at Mercer Medical Center and Trenton Psychiatric Center; past-president of our Mercer County component; instructor at Graduate Hospital, University of Pennsylvania, Philadelphia; member of the American Medical Association; and diplomate of the American Board of Otolaryngology.

FREDERICK G. COESTER

Plastic surgeon Frederick George Coester, MD, of Chatham Township, passed away on April 25, 1992. Dr. Coester was born on January 28, 1929, in Newark. A 1956 graduate of New York Medical College, New York, Dr. Coester completed an internship at the Naval Hospital, Portsmouth, Virginia, and a residency at Roosevelt Hospital, New York, Manhattan Veteran's Hospital, New York, and the former Hospital of Saint Barnabas, Newark. He practiced in Short Hills for 7 years, in West Orange for 16 years, and retired in 1988. Dr. Coester was on staff at Saint Barnabas Medical Center, Livingston. He was a member of our Essex County component; a diplomate of the American Board of Plastic Surgery; and a fellow of the American College of Surgeons. Dr. Coester served in the United States Navy in the late 1950s.

JOHN M. COLLIER

A member of our Camden County component, John Martin Collier, MD, died on May 8, 1992. Born in Wilkes-Barre, Pennsylvania, in 1924, Dr. Collier earned his medical degree from Jefferson Medical College, Pennsylvania, in 1952. He received his New Jersey medical license the following year. An obstetrician-gynecologist, Dr. Collier was affiliated with Cooper Hospital, Camden; Burlington County Hospital, Mount Holly; and the former Philadelphia Lying-In Hospital, Pennsylvania. During his lengthy career, Dr. Collier also served as an assistant director of clinical investigation for McNeil Laboratories, Pennsylvania. Dr. Collier was a member of the American Medical Association and a fellow of the American Academy of Obstetrics and Gynecology. He served in the United States Navy from 1943 to 1946.

VINCENT FELICIANO

Vincent Feliciano, MD, was born on August 28, 1913, in Hawthorne. We received word that he passed away on March 13, 1992. Dr. Feliciano attended Georgetown University School of Medicine, Washington, DC, graduating in 1939. He received his New Jersey medical license in 1940. Dr. Feliciano completed an

internship at Paterson General Hospital in 1941. After completing postgraduate work, Dr. Feliciano served as a flight surgeon with the United States Army Air Corps during World War II. During his lengthy medical career, Dr. Feliciano was president of the medical board of the Greater Paterson General Hospital; medical director of Hawthorne Urgent Care Center for three years; physician for the Hawthorne school system for 25 years; and physician to the Hawthorne Board of Health. Dr. Feliciano resided in Hawthorne and maintained a private general surgical practice for 49 years; he was attending and chairman of the Department of Surgery at Wayne General Hospital. Dr. Feliciano was a member of our Passaic County component and of the American Medical Association, and a fellow of the International College of Surgeons.

JAMES A. FISHER, JR

We have been informed of the death of James Ackerman Fisher, Jr, MD. Dr. Fisher passed away on April 9, 1992, at the age of 72. Dr. Fisher was born in Asbury Park on October 5, 1919. He was awarded a medical degree from the State University of Syracuse, New York, in 1944. He received his New Jersey medical license in 1948. Dr. Fisher completed an internship at the former Fitkin Memorial Hospital, Neptune, in 1946, and a residency at Massachusetts Memorial Hospital, in 1950. Dr. Fisher was an ophthalmologist and practiced in Asbury Park. He was affiliated with Fitkin Memorial Hospital and Monmouth Memorial Hospital, and was a member of our Monmouth County component. Dr. Fisher was a captain in the United States Army during World War II.

JEROME J. FROELICH

We have received word of the death of a member of our Essex County component, Jerome Joseph Froelich, MD, on April 11, 1992. Dr. Froelich was 72 years old. Dr. Froelich was born in Newark, on August 28, 1919. He graduated from Jefferson Medical College, Philadelphia, in 1944. The following year he received his New Jersey medical license. Dr. Froelich was a general practitioner in Newark, and was affiliated with Newark City Hospital, Presbyterian Hospital, and Saint Michael's Medical Center, all in Newark. He was a member of the Academy of Medicine of New Jersey. Dr. Froelich resided in Hillside and retired to Florida. He served in the United States Army as a captain during World War II.

HERBERT N. KOHN

Born in Graz, Austria, on December 10, 1912, Herbert Norman Kohn, MD, of Passaic, passed away on March 5, 1992. Dr. Kohn was awarded a medical degree from the University of Graz, Austria, in 1937. Dr. Kohn completed an internship at Bridgeport Hospital, Connecticut, and a residency at Central Islip State Hospital, New York. He was licensed to practice medicine in New Jersey, New York, Austria, and Connecticut. Dr. Kohn was a psychiatrist. He was director of the Child Guidance Center at St. Mary's Hospital, Passaic, and of the Mental Health Clinic, Passaic. Dr. Kohn was affiliated with St. Mary's Hospital, Beth Israel Hospital, General Hospital Center at Passaic, and Barnert Memorial Hospital Center, all in Passaic. Dr. Kohn was a member of our Passaic County component; a diplomate of the American Board of Psychiatry; and a fellow of the American Orthopsychiatric Association and of the American Psychiatric Association.

ABRAHAM KOLODIN

We regret to announce the death of Abraham Kolodin, MD, on April 16, 1992. He was born on April 23, 1903, in Newark. A 1928 graduate of Columbia University College of Physicians and Surgeons, New York, he received a New Jersey medical license in 1930. Dr. Kolodin was an internist and practiced in Montclair. He was attending at The Mountainside Hospital, Montclair; a member of our Essex County component, of the American Medical Association, and of the Academy of Medicine of New Jersey; a diplomate of the American Board of Internal Medicine; and a fellow of the American College of Physicians.

RICHARD L. LEVINE

Princeton resident Richard Lawrence Levine, MD, died on March 9, 1992. He was 42 years old. Dr. Levine was born on October 13, 1949, in New York City. Dr. Levine was awarded a medical degree from the State University of New York Downstate Medical Center, New York, in 1975. He completed a residency and internship at Bellevue Hospital and Downstate Kings County Hospital, both in New York. Dr. Levine was a family practitioner specializing in emergency medicine and occupational medicine. He was medical director of Professional Medical Services, Lawrenceville; former director of the emergency room at Helene Fuld Medical Center, Trenton; and affiliated with Hamilton Hospital, Trenton. Dr. Levine resided in Yardley, Pennsylvania, and in Princeton. He was a member of our Mercer County component. Dr. Levine was the recipient of the 1991 Small Businessman of the Year for New Jersey Award.

MADAN M. MAKTAL

Middlesex County pediatrician, Madan Mohan Maktal, MD, died on April 26, 1992. Dr. Maktal, born in India on June 6, 1939, was awarded a medical degree from Osmania University, India, in 1962. He interned at Osmania University Hospital, India, and at Somerset Hospital, Somerville; he served a residency at Howard University, Freedman's Hospital, Washington, DC, and at Saint Michael's Medical Center, Newark. He completed a fellowship at Children's Hospital Medical Center, Oakland, California. Dr. Maktal maintained a practice in Edison and Perth Amboy. He was director of pediatrics at John F. Kennedy Medical Center, Edison, and treasurer of the medical staff of Raritan Bay Medical Center, Perth Amboy divison. Dr. Maktal resided in California before relocating to Edison. Dr. Maktal was a diplomate of the American Board of Pediatrics and a member of our Middlesex County component.

I. IRWIN MILLER

Eighty-seven-year-old I. Irwin Miller, MD, of Cranbury, passed away on March 5, 1992. Dr. Miller was born in New York City, on June 26, 1904. He was awarded a medical degree from the University of St. Louis, Missouri, in 1930; the following year, Dr. Miller received his New Jersey medical license. Dr. Miller resided and maintained a family practice in Newark until his retirement in 1983. Dr. Miller was on staff at East Orange General Hospital; Newark Beth Israel Medical Center; Irvington General Hospital; and United Hospitals Medical Center, Newark. He was a member of our Essex County component and of the American Medical Association. Dr. Miller was a veteran of World War II; he was awarded five Battle Stars.

SPERO NECKLES

We regret to inform you of the untimely death of Spero Neckles, MD, on February 28, 1992, at the age of 40. He was born in New York City, on July 14, 1951. Dr. Neckles attended the University of Guadalajara, Mexico, and was awarded a medical degree in 1979. He completed an internship at Danbury Hospital, Danbury, Connecticut, in 1982, and a residency at the University of Connecticut School of Medicine, Farmington, in 1985. Dr. Neckles received his license to practice medicine in New York in 1981; in Connecticut in 1985; and in New Jersey in 1985. Dr. Neckles was an obstetrician and gynecologist and practiced in Englewood. He was affiliated with Holy Name Hospital, Teaneck, and Englewood Hospital. Dr. Neckles was a member of our Bergen County component and a diplomate of the American Board of Obstetrics and Gynecology. Dr. Neckles resided in Franklin Lakes and New Milford.

BABUBHAI S. PATEL

West Long Branch resident, Babubhai Shantabhai Patel, MD, died on April 4, 1992. He was born in India, on August 31, 1935, and was awarded a medical degree from B.J. Medical College, Gujarat University, India, in 1965. He received his New Jersey and Maryland medical licenses in 1976 and 1979, respectively. He completed an internship at B.J. Medical Hospital, India, and a residency at Church Home and Hospital, Baltimore, Maryland, and at Monmouth Medical Center, Long Branch. Dr. Patel practiced medicine in India, before immigrating to the United States. He was an anesthesiologist at Monmouth Medical Center, a diplomate of the American Board of Anesthesiology, and a member of our Monmouth County component.

FRANK REDA

Frank Reda, MD, a member of our Union County component, died on May 14, 1992, at the age of 74. Dr. Reda was an emergency room physician at Elizabeth General Medical Center for 30 years before retiring in 1991; he also was affiliated with Alexian Brothers Hospital, Elizabeth. Dr. Reda maintained a private practice in Elizabeth during his years of service. A 1944 graduate of the University of Bari Medical School, Italy, Dr. Reda completed an internship at St. John's Hospital, New York, and in 1955, he received his New Jersey license. Dr. Reda was a member of the American Medical Association.

BEKEL VENKATACHALAM

Internist and gastroenterologist, Bekel Venkatachalam, MD, of Linwood, died on April 5, 1992. Dr. Venkatachalam was born on September 24, 1938, in India. He was awarded a medical degree from Stanley Medical College, Madras, India, in 1962. Dr. Venkatachalam completed an internship at Stanley Hospital, India, in 1963 and at Mary Immaculate Hospital, New York, in 1964. He served a residency at Shore Memorial Hospital, Somers Point, in 1965, and at Mercy Hospital, Baltimore, Maryland, in 1968. Dr. Venkatachalam practiced in Atlantic City and Northfield, and was senior attending and chief of the Division of Gastroenterology at Shore Memorial Hospital. He was a member of our Atlantic County component and of the American Medical Association, and a fellow of the American College of Physicians.

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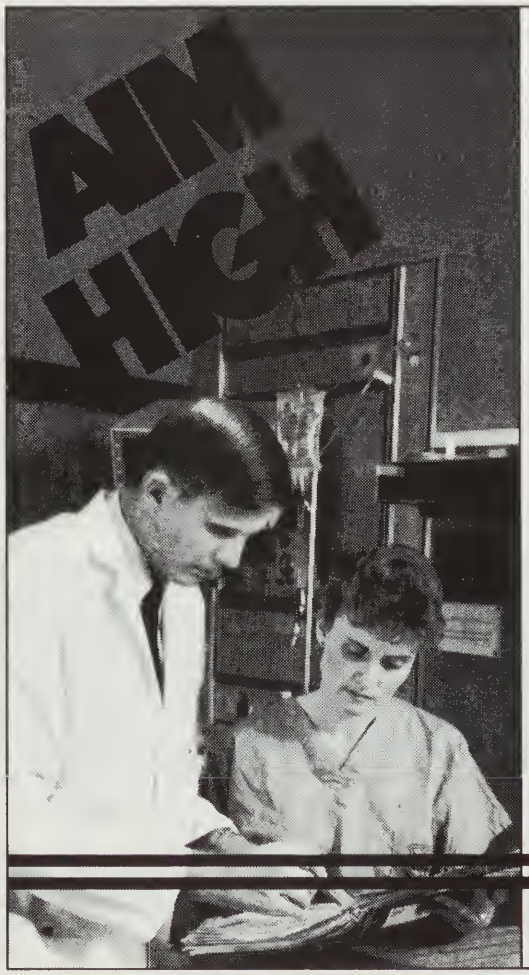
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WHEN ACID REFLUX ERUPTS

Zantac® 150 Tablets
(ranitidine hydrochloride)

Zantac® 300 Tablets
(ranitidine hydrochloride)

Zantac® Syrup
(ranitidine hydrochloride)

BRIEF SUMMARY

The following is a brief summary only. Before prescribing, see complete prescribing information in Zantac® product labeling.

INDICATIONS AND USAGE: Zantac® is indicated in:
1. Short-term treatment of **active duodenal ulcer.** Most patients heal within 4 weeks.
2. **Maintenance therapy** for duodenal ulcer patients at reduced dosage after healing of acute ulcers.
3. The treatment of **pathological hypersecretory conditions** (e.g., Zollinger-Ellison syndrome and systemic mastocytosis).
4. Short-term treatment of **active, benign gastric ulcer.** Most patients heal within 6 weeks and the usefulness of further treatment has not been demonstrated.
5. Treatment of **gastroesophageal reflux disease (GERD).** Symptomatic relief commonly occurs within 1 or 2 weeks after starting therapy. Therapy for longer than 6 weeks has not been studied.

In active duodenal ulcer; active, benign gastric ulcer; hypersecretory states; and GERD, concomitant antacids should be given as needed for relief of pain.

CONTRAINDICATIONS: Zantac® is contraindicated for patients known to have hypersensitivity to the drug.

PRECAUTIONS:

General: 1. Symptomatic response to Zantac® therapy does not preclude the presence of gastric malignancy.
2. Since Zantac is excreted primarily by the kidney, dosage should be adjusted in patients with impaired renal function (see DOSAGE AND ADMINISTRATION). Caution should be observed in patients with hepatic dysfunction since Zantac is metabolized in the liver.

Laboratory Tests: False-positive tests for urine protein with Multistix® may occur during Zantac therapy, and therefore testing with sulfosalicylic acid is recommended.

Drug Interactions: Although Zantac has been reported to bind weakly to cytochrome P-450 *in vitro*, recommended doses of the drug do not inhibit the action of the cytochrome P-450-linked oxygenase enzymes in the liver. However, there have been isolated reports of drug interactions that suggest that Zantac may affect the bioavailability of certain drugs by some mechanism as yet unidentified (e.g., a pH-dependent effect on absorption or a change in volume of distribution).

Increased or decreased prothrombin times have been reported during concurrent use of ranitidine and warfarin. However, in human pharmacokinetic studies with dosages of ranitidine up to 400 mg per day, no interaction occurred; ranitidine had no effect on warfarin clearance or prothrombin time. The possibility of an interaction with warfarin at dosages of ranitidine higher than 400 mg per day has not been investigated.

Carcinogenesis, Mutagenesis, Impairment of Fertility: There was no indication of tumorigenic or carcinogenic effects in lifespan studies in mice and rats at dosages up to 2,000 mg/kg per day.

Ranitidine was not mutagenic in standard bacterial tests (*Salmonella, Escherichia coli*) for mutagenicity at concentrations up to the maximum recommended for these assays.

In a dominant lethal assay, a single oral dose of 1,000 mg/kg to male rats was without effect on the outcome of two matings per week for the next 9 weeks.

Pregnancy: ***Teratogenic Effects: Pregnancy Category B:*** Reproduction studies have been performed in rats and rabbits at doses up to 160 times the human dose and have revealed no evidence of impaired fertility or harm to the fetus due to Zantac. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

Nursing Mothers: Zantac is secreted in human milk. Caution should be exercised when Zantac is administered to a nursing mother.

Pediatric Use: Safety and effectiveness in children have not been established.

Use in Elderly Patients: Ulcer healing rates in elderly patients (65 to 82 years of age) were no different from those in younger age-groups. The incidence rates for adverse events and laboratory abnormalities were also not different from those seen in other age-groups.

ADVERSE REACTIONS: The following have been reported as events in clinical trials or in the routine management of patients treated with Zantac®. The relationship to Zantac therapy has been unclear in many cases. Headache, sometimes severe, seems to be related to Zantac administration.

Central Nervous System: Rarely, malaise, dizziness, somnolence, insomnia, and vertigo. Rare cases of reversible mental confusion, agitation, depression, and hallucinations have been reported, predominantly in severely ill elderly patients. Rare cases of reversible blurred vision suggestive of a change in accommodation have been reported.

Cardiovascular: As with other H_2-blockers, rare reports of arrhythmias such as tachycardia, bradycardia, atrioventricular block, and premature ventricular beats.

Gastrointestinal: Constipation, diarrhea, nausea/vomiting, abdominal discomfort/pain, and rare reports of pancreatitis.

Hepatic: In normal volunteers, SGPT values were increased to at least twice the pretreatment levels in 6 of 12 subjects receiving 100 mg q.i.d. intravenously for 7 days, and in 4 of 24 subjects receiving 50 mg q.i.d. intravenously for 5 days. There have been occasional reports of hepatitis, hepatocellular or hepatocanalicular or mixed, with or without jaundice. In such circumstances, ranitidine should be immediately discontinued. These events are usually reversible, but in exceedingly rare circumstances death has occurred.

Musculoskeletal: Rare reports of arthralgias.

Hematologic: Blood count changes (leukopenia, granulocytopenia, thrombocytopenia) have occurred in a few patients. These were usually reversible. Rare cases of agranulocytosis, pancytopenia, sometimes with marrow hypoplasia, and aplastic anemia and exceedingly rare cases of acquired immune hemolytic anemia have been reported.

Endocrine: Controlled studies in animals and man have shown no stimulation of any pituitary hormone by Zantac® (ranitidine HCl) and no antiandrogenic activity, and cimetidine-induced gynecomastia and impotence in hypersecretory patients have resolved when Zantac has been substituted. However, occasional cases of gynecomastia, impotence, and loss of libido have been reported in male patients receiving Zantac, but the incidence did not differ from that in the general population.

Integumentary: Rash, including rare cases suggestive of mild erythema multiforme, and, rarely, alopecia.

Other: Rare cases of hypersensitivity reactions (e.g., bronchospasm, fever, rash, eosinophilia), anaphylaxis, angioneurotic edema, and small increases in serum creatinine.

OVERDOSAGE: Information concerning possible overdosage and its treatment appears in the full prescribing information.

DOSAGE AND ADMINISTRATION: (See complete prescribing information in Zantac® product labeling.)

Active Duodenal Ulcer: The current recommended adult oral dosage is 150 mg or 10 mL (2 teaspoonfuls equivalent to 150 mg of ranitidine) twice daily. An alternate dosage of 300 mg or 20 mL (4 teaspoonfuls equivalent to 300 mg of ranitidine) once daily at bedtime can be used for patients in whom dosing convenience is important. The advantages of one treatment regimen compared to the other in a particular patient population have yet to be demonstrated.

Maintenance Therapy: The current recommended adult oral dosage is 150 mg or 10 mL (2 teaspoonfuls equivalent to 150 mg of ranitidine) at bedtime.

Pathological Hypersecretory Conditions (such as Zollinger-Ellison syndrome): The current recommended adult oral dosage is 150 mg or 10 mL (2 teaspoonfuls equivalent to 150 mg of ranitidine) twice a day. In some patients it may be necessary to administer Zantac® 150-mg doses more frequently. Dosages should be adjusted to individual patient needs, and should continue as long as clinically indicated. Dosages up to 6 g per day have been employed in patients with severe disease.

Benign Gastric Ulcer: The current recommended adult oral dosage is 150 mg or 10 mL (2 teaspoonfuls equivalent to 150 mg of ranitidine) twice a day.

GERD: The current recommended adult oral dosage is 150 mg or 10 mL (2 teaspoonfuls equivalent to 150 mg of ranitidine) twice a day.

Dosage Adjustment for Patients with Impaired Renal Function: On the basis of experience with a group of subjects with severely impaired renal function treated with Zantac, the recommended dosage in patients with a creatinine clearance less than 50 mL/min is 150 mg or 10 mL (2 teaspoonfuls equivalent to 150 mg of ranitidine) every 24 hours. Should the patient's condition require, the frequency of dosing may be increased to every 12 hours or even further with caution. Hemodialysis reduces the level of circulating ranitidine. Ideally, the dosing schedule should be adjusted so that the timing of a scheduled dose coincides with the end of hemodialysis.

HOW SUPPLIED: Zantac® 300 Tablets (ranitidine hydrochloride equivalent to 300 mg of ranitidine) are yellow, capsule-shaped tablets embossed with "ZANTAC 300" on one side and "Glaxo" on the other. They are available in bottles of 30 (NDC 0173-0393-40) tablets and unit dose packs of 100 (NDC 0173-0393-47) tablets.

Zantac® 150 Tablets (ranitidine hydrochloride equivalent to 150 mg of ranitidine) are white tablets embossed with "ZANTAC 150" on one side and "Glaxo" on the other. They are available in bottles of 60 (NDC 0173-0344-42) and 100 (NDC 0173-0344-09) tablets and unit dose packs of 100 (NDC 0173-0344-47) tablets.

Store between 15° and 30°C (59° and 86°F) in a dry place. Protect from light. Replace cap securely after each opening.

Zantac® Syrup, a clear, peppermint-flavored liquid, contains 16.8 mg of ranitidine hydrochloride equivalent to 15 mg of ranitidine per 1 mL in bottles of 16 fluid ounces (one pint) (NDC 0173-0383-54).

Store between 4° and 25°C (39° and 77°F). Dispense in tight, light-resistant containers as defined in the USP/NF.

September 1991

Glaxo Pharmaceuticals™
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Research Triangle Park, NC 27709

Zantac® Syrup:
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Please see Brief Summary of Prescribing Information on adjacent page.
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Newswatch

COMPREHENSIVE HEALTH REFORM...

Along with other major private sector state organizations, the Medical Society of New Jersey (MSNJ) is helping to develop a plan to relieve the crisis resulting from a federal court decision striking down New Jersey's method of financing uncompensated hospital care. Participants in the Coalition for Health Care Reform, which is working to develop a plan, include MSNJ, the New Jersey Hospital Association, the Business and Industry Association, the New Jersey State Nurses Association, and several other groups.

In the view of MSNJ leaders, the current court-made crisis is an opportunity to effect major changes in the state's health care system. For example, a subsidized insurance program could be developed so that people on limited incomes could obtain insurance and, thus, pay for physician services. The system that was struck down provided reimbursement only for hospital care.

There also may be opportunities to reduce over-regulation of health care, particularly with regard to hospital DRG-based financing, certificate-of-need requirements, excessive paperwork demands, and state inspections. Tort reform also could be recommended by the Coalition. A Coalition report tentatively is targeted for September 16, 1992.

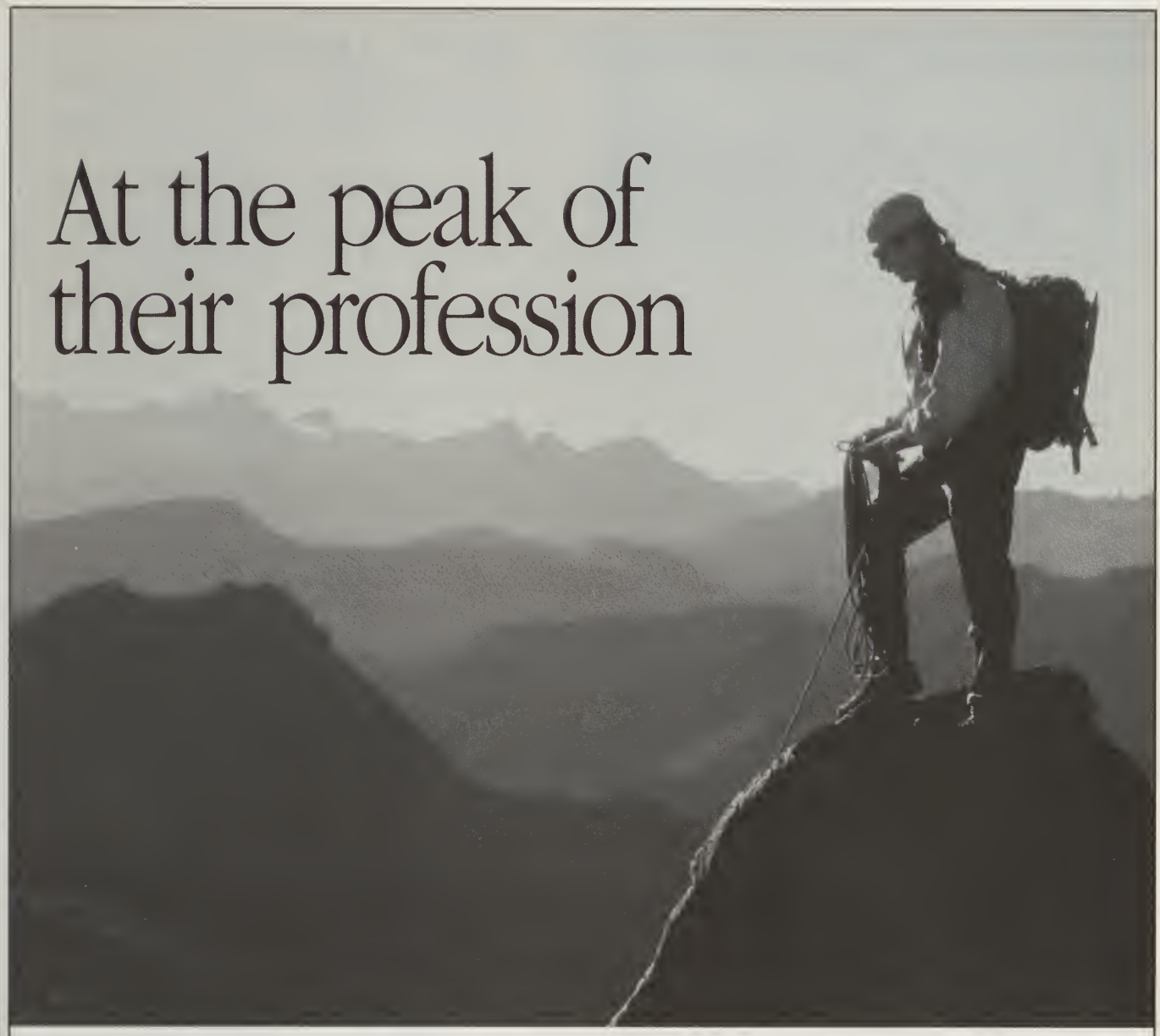
One threat, however, is that New Jersey could follow the lead of Minnesota and other states in establishing a "provider tax" on hospitals, physicians, and other health care entities

in order to finance uncompensated care. The federal Health Care Financing Administration (HCFA) is promoting provider taxes; HCFA says such taxes may be used to draw down federal matching funds for Medicaid.

One alternative to a provider tax is a payroll tax on employers. This option has been advocated by Senate Health and Human Services Committee Chairman C. Louis Bassano of Union and other key state figures. Another possible funding alternative is a health risk tax on tobacco and alcohol products, which account for many of the health problems covered by uncompensated care. The New Jersey State Department of Health estimates that 40 percent of uncompensated care expenditures involve treatment caused by addictive behaviors. The Coalition for a Healthy New Jersey has been formed to promote alcohol and tobacco taxes to finance uncompensated care, fund alcohol and smoking-related programs, and serve as an economic disincentive for smoking and drinking. MSNJ is a member of the Coalition for a Healthy New Jersey.

MSNJ's executive committee and Board of Trustees are overseeing the development and implementation of MSNJ's negotiation strategy within the Coalition for Health Care Reform. Substantial assistance and advice are being provided by the MSNJ's Committee on Legislative Initiatives and by MSNJ's Committee on Uncompensated Care.

President William E. Ryan, MD, urges MSNJ members to share their concerns about state health reform with members of the MSNJ Board of Trustees. September 1992



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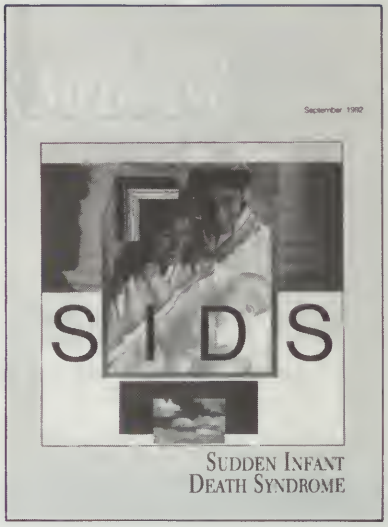
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The Cover

We present a special issue on sudden infant death syndrome. On page 666, guest editor Thomas Hegyi, MD, begins the presentation with an overview of the subject. Cover illustration: Williams & Philips.

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MSNJ NEWSLETTER

NEW PLAN OPTIONS

"The cost of health care insurance sure is high these days." "I am looking to reduce the premiums I pay for insurance." "I am willing to share in more of the costs of the smaller medical expenses if it helps reduce premiums." "I want comprehensive protection from my insurance if I am seriously injured or become very sick."

Do these statements reflect your thinking on health care insurance? If so, the new Medical Society of New Jersey (MSNJ) health care program plan option, Blue Cross-Wraparound, may be just the coverage for you.

The Blue Cross-Wraparound Plan was designed based upon input from a membership services committee of peers and survey responses received from over 500 member physicians. The Plan offers comprehensive yet more cost-efficient coverage by applying deductible and copayment provisions to medical-surgical and major medical-covered expenses. Eligible hospital admissions are covered on a first dollar basis (no deductible; no copayment) for up to 365 days per year.

Features of the new Blue Cross-Wraparound Plan that typically are not found or are more limited under other plans include: full plan benefits for hospital admissions for tuberculosis, mental/nervous conditions, and drug addiction; annual limit on out-of-pocket expense attributable to deductible and copayment; full coverage when traveling at home or abroad, including Medicare eligibles traveling outside the U.S.; full coverage for dependent children to age 23; and portability of coverage. Participation may be continued by members for life. In addition, widows and widowers of participating members may continue their coverage for life.

If you would like to receive more information on the Blue Cross-Wraparound Plan, contact, Donald F. Smith & Associates, P.O. Box 6509, Lawrenceville, NJ 08648-0509 or call Jean Wasielczyk, Bill Bloor, or Ron Keefe at 1/609/895-1616 or 1/800/257-9228.

AMA DELEGATION

Joseph A. Riggs, MD, chairman, and Irving P. Ratner, MD, vice-chairman of the American Medical Association (AMA) Delegation, attended the AMA Annual Meeting in Chicago. They report on the activities of the New Jersey delegation.

Many important issues were discussed and studied. New Jersey presented 13 of the 309 resolutions:

1. **Resolution #5—Ethics of Self-Referral** (Reference Committee on Amendments to Constitution and Bylaws)—overwhelmingly supported and adopted.

2. **Resolution #132—Resource-Based Relative Value Scale (RBRVS)** (Reference Committee "A")—substitute resolution adopted.

3. **Resolution #133—Access to Care by Medicare Beneficiaries** (Reference Committee "A")—referred to Board of Trustees for decision.

4. **Resolution #134—Assisting Surgeons/Medicare** (Reference Committee "A")—reaffirmed as existing AMA policy.

5. **Resolution #150—Cost and Quality of Care by Nonphysicians** (Reference Committee "A")—substitute resolution adopted.

6. **Resolution #220—Unnecessary Regulation)** (Reference Committee "B")—reaffirmed as existing AMA policy.

7. **Resolution #229—Negotiation for Physicians** (Reference Committee "B")—substitute resolution adopted.

8. **Resolution #237—Freedom of Contract** (Reference Committee "B")—referred to Board of Trustees; may enter as amicus.

9. **Resolution #238—Statutory Interpretation on Limiting Charge Applicability** (Reference Committee "B")—referred to Board of Trustees.

10. **Resolution #265—Medicare Limiting Charge and Major Medical Insurance** (Reference Committee "B")—referred to Board of Trustees for decision.

11. **Resolution #511—Repeal of Offensive Federal Regulations** (Reference Committee "E")—substitute resolution adopted.

12. **Resolution #512—Long-term Use of Intravenous Antibiotics in the Treatment of Lyme Disease** (Reference Committee "E")—substitute resolution adopted.

13. **Resolution #531—Medical Waste Registration** (Reference Committee "E")—substitute resolution adopted.

SPORTS MEDICINE '92

Sports Medicine '92 will be held on October 14, 1992, from 8:15 A.M. to 12:40 P.M. This workshop is sponsored by the Academy of Medicine of New Jersey and the Committee on Medical Aspects of Sports, Medical Society of New Jersey. This program is open to physicians, nurses, coaches, school administrators, and trainers. Covering various aspects in the current care of athletes, the continuing medical education workshop has been designated for 3 hours in category 1 of the Physicians' Recognition Award. For further information, contact Sue Arnone, MSNJ headquarters, 1/609/896-1766.

MSNJ WRITING COMPETITION

INTERNS/RESIDENTS/FELLOWS/STUDENTS

A **$500 AWARD** will be presented by the Medical Society of New Jersey to the intern, resident, fellow, or 4th-year medical student who submits the best paper on a clinical subject for the Society's 1992 Competition.

Entries should be "sponsored" by a faculty member, and all papers submitted should be of sufficient quality to be considered for publication in *NEW JERSEY MEDICINE*.

Entrants need not be members of the Medical Society of New Jersey, but must be in training at a New Jersey hospital, studying at an institution in the state of New Jersey, or be a resident of New Jersey.

Entries must be submitted by November 1, 1992. The winning paper will be published in a future issue of *NEW JERSEY MEDICINE*. Other noteworthy manuscripts will be considered for publication by the Editorial Board of *NEW JERSEY MEDICINE*.

Send two copies of the manuscript to:

Howard D. Slobodien, MD
NEW JERSEY MEDICINE
Two Princess Road, Lawrenceville, NJ 08648

All papers and photographs will be returned. If you have any questions, please call the offices of *NEW JERSEY MEDICINE* at 1/609/896-1766.



The 1992-1993 Medical Society of New Jersey Board of Trustees. From left to right, first row: Judy Forster; Gerald H. Rozan, MD; Bernard Robins, MD; Fred M. Palace, MD; Joseph N. Micale, MD; William E. Ryan, MD; Joseph A. Riggs, MD; Louis L. Keeler, MD; and Leticia V. DeCastro, MD. From left to right, second row: Mark T. Olesnicky, MD; R. Gregory Sachs, MD; Irving P. Ratner, MD; S. Manzoor Abidi, MD; G. Gerson Grodberg, MD; Carl Restivo, Jr, MD; Anthony P. Caggiano Jr, MD; Stevan Adler, MD; Shah M. Chaudhry, MD; Churchill L. Blakey, MD; George T. Hare, MD; and Angelo S. Agro, MD. Missing from this photograph, taken at the MSNJ Annual Meeting in Atlantic City, are Michael M. Heeg, MD; Philip J. Jasper, MD; and Herbert Langer, MD.

Attendance at Meetings of the Board of Trustees

County and Specialty Societies, Academy of Medicine of New Jersey, MSNJ Auxiliary, and AMA Delegation

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May 6 ..... Harry L. Chaikin, MD, President

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Lois J. Copeland, MD
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May 6 ..... Alfred A. Alessi, MD

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April 15 ..... Ardith R. Lane, Executive Director
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March 15 ..... Giovanni Lima, MD, President-Elect
April 15 ..... Howard M. Eisenstodt, MD
May 6 ..... Arthur R. Ellenberger, Executive Director

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March 15 ..... Churchill L. Blakey, MD
May 2 ..... Churchill L. Blakey, MD

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Louis G. Fares, MD
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Rajendra Prasad, MD, President-Elect
April 15 ..... Louis G. Fares, MD
Linda L. McGhee, Executive Director
May 2 ..... Louis G. Fares, MD
May 6 ..... Louis G. Fares, MD
Gabriel F. Sciallis, MD

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March 15 ..... Walter J. Kahn, MD
Mohan Makhija, MD, President
April 15 ..... Walter J. Kahn, MD
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May 2 ..... Walter J. Kahn, MD
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May 6 ..... Walter J. Kahn, MD

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Rudolf E. Schwaeble, MD
Augustus L. Baker, Jr, MD
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March 15 ..... Paul J. Hirsch, MD
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May 2 ..... Bartholomew R. D'Ascoli, MD

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May 2 ..... Irene Rosenthal
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February 9 ..... Robert C. Emery, MD, President
March 15 ..... Robert C. Emery, MD, President
April 15 ..... Robert C. Emery, MD, President
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January 19 ..... John G. Winant, Jr, MD
February 9 ..... John G. Winant, Jr, MD
March 15 ..... John G. Winant, Jr, MD

New Jersey State Society of Anesthesiologists
March 15 ..... Stanley Bresticker, MD

Dermatological Society of New Jersey
February 9 ..... Lewis P. Stolman, MD

Electrodiagnostic Medicine Association of New Jersey
February 9 ..... Kutumba S. Pitta, MD
Michael Sutula, DO

New Jersey Chapter, American College of Emergency Physicians
January 19 ..... Richard M. Schwab, MD
February 9 ..... Richard M. Schwab, MD
April 15 ..... Richard M. Schwab, MD
May 2 ..... Michael Dudnick, DO

New Jersey Society of Internal Medicine
April 15 ..... Frank J. Malta, MD
May 2 ..... Frank J. Malta, MD

New Jersey Association of Medical Specialty Societies
March 15 ..... Stanley Bresticker, MD

New Jersey Obstetrical and Gynecological Society
January 19 ..... John D. Franzoni, MD
Gordon N. Lockhart, MD
February 9 ..... John S. Garra, MD
March 15 ..... John D. Franzoni, MD
April 15 ..... John D. Franzoni, MD
May 2 ..... John D. Franzoni, MD
May 6 ..... John D. Franzoni, MD

New Jersey Academy of Ophthalmology and Otolaryngology
March 15 ..... Saul M. Tischler, MD
Donald J. Cinotti, MD

New Jersey Pediatric Society
January 19 ..... Barry S. Prystowsky, MD
March 15 ..... Barry S. Prystowsky, MD

New Jersey Psychiatric Association
January 19 ..... Rena M. Nora, MD
February 9 ..... Rena M. Nora, MD

New Jersey Society of Physical Medicine and Rehabilitation
February 9 ..... Kutumba S. Pitta, MD

Radiological Society of New Jersey
May 2 ..... David I. Kingsley, MD

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January 19 ..... Charles J. Heitzmann, Executive Director
Ronnie Davidson, EdD, Dir, Research & Education

Gerald Shapiro, MD

February 9 ..... Charles J. Heitzmann, Executive Director
Ronnie Davidson, EdD, Dir, Research & Education
Gerald Shapiro, MD

March 15 ..... Charles J. Heitzmann, Executive Director
Ronnie Davidson, EdD, Dir, Research & Education
Gerald Shapiro, MD
Sherman Garrison, MD

April 15 ..... Charles J. Heitzmann, Executive Director
Ronnie Davidson, EdD, Dir, Research & Education
Sherman Garrison, MD

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Marion Geib, President-Elect

February 9 ..... Jean Taboada, President
Marion Geib, President-Elect
Jane Lorber

March 15 ..... Jean Taboada, President
Jane Lorber

April 15 ..... Jean Taboada, President
Marion Geib, President-Elect

May 2 ..... Jean Taboada, President
Jane Lorber

May 6 ..... Marion Geib, President
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Ralph J. Fioretti, MD
Karl T. Franzoni, MD
John S. Madara, MD
Joseph N. Micale, MD
Henry J. Mineur, MD
Joseph A. Riggs, MD
Robert H. Stackpole, MD
William E. Ryan, MD

February 9 ..... Ralph J. Fioretti, MD
Karl T. Franzoni, MD
Henry J. Mineur, MD
Joseph A. Riggs, MD
Edward A. Schauer, MD

March 15 ..... Harry M. Carnes, MD
Karl T. Franzoni, MD
John S. Madara, MD
Joseph N. Micale, MD
Henry J. Mineur, MD
Joseph A. Riggs, MD
Edward A. Schauer, MD
Robert H. Stackpole, MD
William E. Ryan, MD

April 15 ..... Harry M. Carnes, MD
Karl T. Franzoni, MD
Joseph N. Micale, MD
Henry J. Mineur, MD
Joseph A. Riggs, MD
Edward A. Schauer, MD
William E. Ryan, MD

May 2 ..... Ralph J. Fioretti, MD
Karl T. Franzoni, MD
John S. Madara, MD
Joseph N. Micale, MD
Henry J. Mineur, MD
Joseph A. Riggs, MD
Edward A. Schauer, MD
Robert H. Stackpole, MD
William E. Ryan, MD

May 6 ..... Ralph J. Fioretti, MD
Karl T. Franzoni, MD
John S. Madara, MD
Joseph N. Micale, MD
Henry J. Mineur, MD
Joseph A. Riggs, MD
Edward A. Schauer, MD
William E. Ryan, MD

AMA Alternate Delegates

January 19 ..... Joel S. Cherashore, MD
Donald J. Holtzman, MD
A. Ralph Kristeller, MD
Mark T. Olesnicky, MD
Carl Restivo, Jr, MD
Robert J. Weierman, MD

February 9 ..... Douglas M. Costabile, MD
George T. Hare, MD
A. Ralph Kristeller, MD
Mark T. Olesnicky, MD
Irving P. Ratner, MD
Robert J. Weierman, MD

March 15 ..... Douglas M. Costabile, MD
Donald J. Holtzman, MD
A. Ralph Kristeller, MD
Mark T. Olesnicky, MD
Irving P. Ratner, MD
Carl Restivo, Jr, MD
Robert J. Weierman, MD

April 15 ..... Joel S. Cherashore, MD
Douglas M. Costabile, MD
George T. Hare, MD
Donald J. Holtzman, MD
A. Ralph Kristeller, MD
Mark T. Olesnicky, MD
Irving P. Ratner, MD
Carl Restivo, Jr, MD

May 2 ..... Joel S. Cherashore, MD
Douglas M. Costabile, MD
George T. Hare, MD
Donald J. Holtzman, MD
A. Ralph Kristeller, MD
Mark T. Olesnicky, MD
Irving P. Ratner, MD
Carl Restivo, Jr, MD
Robert J. Weierman, MD

May 6 ..... Joel S. Cherashore, MD
Douglas M. Costabile, MD
George T. Hare, MD
Donald J. Holtzman, MD
A. Ralph Kristeller, MD
Mark T. Olesnicky, MD
Irving P. Ratner, MD
Carl Restivo, Jr, MD

IMPORTANT NOTICE
TO ALL PHYSICIANS AND HOSPITALS

New legislation (S-1008) has been proposed in Trenton seeking to "crack down on health care providers" who are suspected of submitting fraudulent claims to health insurance carriers in much the same manner as is now done regarding claims to automobile insurance carriers.

As many of us are aware, previous experience in the automobile area has shown that the legitimate objectives pursued by the bill's sponsors unfortunately may translate in practice into the erroneous pursuit of innocent practitioners in many instances.

We represent several health care providers who have experienced first-hand the trauma of the investigation of inaccurate suspicions of fraud, an experience sure to be shared by numerous others with the passage of the pending legislation in its present form.

To assist us in our planned effort to work with the Legislature to bring some balance to this legislation from the perspective of the health care practitioner, we would appreciate your contacting us regarding your experiences involving filing claims with insurance companies, payment of those claims and dealings with State regulatory agencies at the address provided below, so that we might best be in a position to represent the interests of health care practitioners at this important stage of the process:

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PROFESSIONAL LIABILITY

MALPRACTICE VERDICTS

Death of baby. A pediatrician prescribed the broad-based antibiotic, Amoxicillin®, in response to a baby's frequent ear infections. Several days after receiving one of a series of such prescriptions, the baby's mother brought the baby to an urgent care center when the pediatrician was unavailable. A moonlighting resident provided a sample bottle of Augmentin® and a prescription for erythromycin. For two weeks the symptoms abated. Then the baby developed meningitis and succumbed at the age of seven months. A malpractice action was brought against the resident.

Testifying for the plaintiff in this New Jersey lawsuit, a pediatric neurologist contended that half of all ear infections are bacterial, and that approximately 5 percent of these bacterial infections result from *Haemophilus influenzae* B, which can lead to meningitis. The baby's history of infections, testified the expert, suggested that the infections were bacterial. The original prescription should have been continued, in the expert's opinion, in order to protect against *H. influenzae* B.

But, claimed the defendant, Amoxicillin® apparently had been unsuccessful. Moreover, erythromycin would be effective against mycoplasma, which could be causing the symptoms. The defendant's expert doubted whether Amoxicillin® would have prevented *H. influenzae* B, and the defendant further demonstrated that he had advised the mother to visit the pediatrician within four days.

The jury found for the plaintiff and awarded $2.1 million in damages. The award included a substantial amount for emotional distress, including the mother's distress from having the baby die in her arms. Most of the award, however, was for the baby's pain and suffering. In this regard, the jury may have been influenced by a graphic recounting of the baby's symptoms.

Complications of eye surgery. A severely myopic 24-year-old woman consented to epikeratophakia, or implantation of a lens taken from a cadaver. Previously she had changed prescriptions for corrective vision 21 times in 12 years. Before consenting to the surgical procedure, the patient viewed a patient education videotape six times. The videotape, she said, persuaded her that the procedure was reversible. For more than two years following the surgery, the patient maintained she experienced significant pain. At that point the lens was removed, but according to experts she permanently suffers up to 30 percent glare disability that prevents her from working full time, driving at night, reading in direct light or for an extended period, or engaging in sports or needlework.

The patient brought a malpractice action in a New Jersey trial court, alleging that the ophthalmologist who performed the operation should not have recommended the procedure because she did not meet established criteria, that the physician improperly advised her that complications could be reversed, that he failed to obtain informed consent because he neglected to inform her he had only performed the procedure ten times on myopic patients, and that the documented failure rate exceeded 10 percent.

In his defense, the ophthalmologist argued that the patient's frequent change of prescriptions for spectacles and her difficulty in tolerating contact lenses made her an appropriate candidate for the procedure. He contended that the glare resulted from a postoperative infection. The videotape, he asserted, merely advises patients that the implanted lens could be removed, not that any resulting glare could be corrected. Because only 3 percent of patients experience glare, he said it was unnecessary to mention this possible side effect.

These contentions of the defense were disputed by the plaintiff, who claimed that the postoperative infection affected both eyes and, therefore, would not have caused scarring in only one eye. She further claimed that she clearly could tolerate contact lenses, which she consistently wore to court.

The jury decided the surgery was unnecessary. The jurors further agreed with the plaintiff that there was no informed consent, but—in view of the low complication rate and the fact that ten similar patients of the physician had consented to the procedure and none had refused it—the jury decided that a reasonable person would have given consent. Damages of $1.5 million were awarded, but post-trial motions were pending.

C-section delayed. In another recently decided New Jersey case, an action was brought against a hospital and its administrator following a verdict in favor of an obstetrician and following a subsequent state Supreme Court ruling that the verdict did not protect the other subsequently named defendants.

On a Saturday evening at approximately 9:30 P.M., a pregnant woman presented in the emergency department, and fetal distress was observed. The attending obstetrician determined a

cesarean section was indicated, but an extensive delay ensued while an assisting obstetrician and pediatrician were located. As a result of the delay, the baby allegedly suffered hypoxia for 103 minutes and, consequently, sustained profound brain damage, blindness, mental retardation, and the inability to walk or talk. The plaintiff's claim was that the hospital and administrator should have ensured that C-sections could be performed within 30 minutes.

According to the defense, the delay was produced by the physician's failure to decide early on to perform a C-section. Records indicated, however, that the patient was prepped for more than 30 minutes. The plaintiff showed that the obstetrician, and other obstetricians, had been trying for years to expedite procedures for performing C-sections.

Damages of $5.2 million accompanied the jury's verdict for the plaintiff, who had shown that more than $100,000 of services and equipment would be needed annually for the anticipated 30 to 50 years of life. A videotape of the child's face during physical therapy was used to show that the child experienced pain and suffering, and the court also instructed the jury that it could award damages for loss of enjoyment of life.

C-section denied. Approximately 27 weeks into term a pregnant woman's membranes ruptured, and she was admitted to a level 3 perinatal center. At discharge, the patient was instructed to inform her obstetrician if her temperature became elevated or the nature of her vaginal discharge changed. At 33 weeks, she experienced a temperature of 100.4°F and a yellowish discharge. She presented at the hospital emergency department. The emergency physician observed purulent vaginal discharge and an effaced cervix dilated at 2 centimeters. An obstetrician-gynecologist resident disagreed that the cervix was effaced or dilated or that the discharge, although yellowish, was purulent. The patient was admitted to the hospital for 14 hours, during which an elevated white blood cell (WBC) count was found. Broad-based antibiotics were provided prophylactically upon discharge. Two days later a stillborn girl was delivered by emergency C-section.

An immediate C-section should have been performed following the second admission, the plaintiff's expert obstetrician-gynecologist told a New Jersey court. The success rate for such a procedure following 33 weeks' gestation is 97 percent, the expert contended. He further stated that a sonogram and repeat non-stress test should have been performed, and that the fetus was in a transverse position so that a C-section would have been necessary anyway.

An elevated WBC is not unusual during pregnancy and does not signal infection, the defendant countered. He further showed that there were no abnormalities in the fetal heart rate.

The plaintiff won an award of $350,000, as the jury was influenced by claims of post-traumatic stress disorder even though she did not undergo psychotherapy. Three sons subsequently were born to the plaintiff, but she asserted that she always wanted a girl and frequently is reminded of her loss.

Abdominal pain. Diverticulitis with impacted fecal material was a family physician's diagnosis when a 52-year-old man presented with generalized abdominal pain that was most severe in the lower left quadrant. The next day, however, the pain was felt in the lower right quadrant, and the patient was hospitalized as a result of a rupture that had become walled off.

Claiming that the extended hospital stay and a four-to-five-inch surgical scar were the product of the physician's negligence in failing to conduct further tests, the patient brought a malpractice action in New Jersey. The essence of the defense was that the initial diagnosis was reasonable and that the rupture would have occurred even if the patient had been admitted to the hospital a day earlier. Moreover, argued the defense, the patient was at least comparatively negligent for failing to contact a physician for several hours after the pain shifted. The verdict was for the defense.

Patient followup. A car was hit broadside and flipped over, and the passenger was brought to a hospital emergency department where a resident failed to diagnose a nondisplaced cervical fracture. On the following day, a radiologist made the correct determination. The patient was not notified, however, and subsequently she sued for damages in New Jersey, claiming that permanent pain and restricted movement resulted from the resident's failure to make the correct diagnosis and from both physicians' failure to contact her.

But steps were taken to contact the patient the next day, contended the physicians. The patient was a visitor from Iran, and they asserted that attempts were made to locate her at the address she had provided. In addition, they noted that the plaintiff's expert witness had been denied privileges at the defendant hospital and that the witness's sister was the driver of the vehicle. The jury decided in favor of the defense.

MALPRACTICE TIPS

Medication errors. Physician-owned insurance carriers throughout the country now make an average indemnity payment of $94,800 for medication errors, and *Medical Liability Monitor* has offered suggestions for preventing liability in this area. Most successful claims, according to an ex-

pert quoted by the newsletter, involve: allergic reactions; use of nonsteroidal, anti-inflammatory agents in patients who also are taking aspirin; contraindications; and failures to warn patients of side effects.

An example provided by the newsletter reads: "A patient sprains his ankle, says he has 'no allergies,' and is treated with naproxen. Four days later he suffers an extensive gastrointestinal bleed. He failed to tell the doctor he was taking aspirin daily because he thought that over-the-counter medications 'didn't count' when he was asked what drugs he was taking."

The advice to physicians included making the correct diagnosis, identifying the appropriate medication with the least toxicity, ruling out contraindications, and communicating to the patient—effectively—when and how much of the medication to take and which side effects to take seriously. As a communication aide, the expert recommended the use of printed drug information sheets like those provided by the American Medical Association (AMA).

New practice guidelines. Seven common and costly surgical procedures are addressed in practice guidelines recently issued jointly by the Rand Corporation and the AMA. They are: coronary bypass surgery; coronary balloon angioplasty; coronary angiography; hysterectomy; cataract extraction; carotid endartectomy; and abdominal aortic aneurysm surgery. The AMA has cautioned that proper use of these guidelines awaits their conversion into practice parameters by physician groups.

Breast implant suits. Does the apparent paucity of silicone implant suits against physicians indicate that actions against physicians will not be brought wholesale? Commentators appear divided over the question of whether physicians will be frequently named as parties in such suits. But, some patients are beginning to charge that their doctors failed to warn them of the risks. The lack of clinical trials of the implants also may substantiate claims of malpractice, comments *Malpractice Liability Monitor.* Meanwhile, a six-page overview paper for patients has been produced by the American Society of Plastic and Reconstructive Surgeons. To obtain a copy, contact Marge Bolling at MSNJ executive offices.

Hearing interpreters for the deaf. Although not strictly malpractice related, potential claims of violations of the new Americans with Disabilities Act may interest readers. The AMA has issued a memorandum advising that some advocates of the hearing impaired are demanding that physicians pay for interpreters for deaf patients. In some cases interpreters accompany the patient to the physician's office unannounced, the memo warns.

Under the law, case-by-case decisions will determine which assistive devices and services are appropriate for individual patients. Paid interpreters are not routinely required. The decisions will turn on the patient's acceptance of less costly alternatives, such as use of a note pad, written materials, a computer, the presence of a family member or friend, and forms for taking medical histories or obtaining other important information.

HEALTH CARE FINANCING

Hospital CN requests soar. On July 1, 1992, the New Jersey State Department of Health (NJDOH) released a list of letters of intent recently filed for certificates of need (CN). As analyzed by the Medical Society of New Jersey (MSNJ), the list includes 102 projects totaling an estimated $718.6 million and another 51 projects—including a new children's hospital affiliated with Cooper Hospital in Camden—for which no amount was stated.

The proposed projects, all sponsored by hospitals, are concentrated in Essex, Union, Bergen, and Hudson counties. Among major projects are a new patient tower at Englewood Hospital, new operating suites at JFK Health Systems, and construction at the General Hospital Center at Passaic, Pascack Valley Hospital, Riverview Medical Center, and Community Memorial Hospital. A CN moratorium has been in effect since last year, while NJDOH has sought to obtain approval of its proposed State Health Plan. Under the Health Care Cost Reduction Act proposed by the administration and enacted by the Democratic-controlled Legislature last year, a $255 million annual ceiling for CN projects still is in effect.

Comparing cost effectiveness. In a speech delivered to a conference sponsored by the state's Citizens' Committee on Biomedical Ethics and reprinted in *Trends in Health Care, Law & Ethics,* former University of Minnesota President Kenneth H. Keller analyzed the ethical and economic aspects of high-technology health care. Dr. Keller observed "a tendency to romanticize high-technology medicine . . . to describe it as better or worse than it is in reality," and he advised against accepting the judgments of both technophiles and technophobes.

Estimating that about one-fourth of the nation's health bill involves technology, Dr. Keller used the example of end-stage heart disease to compare alternative therapies. Conventional use of drugs in a closely supervised clinical environment, he stated, prolongs life for an average of six months, but the quality of that life is very low. By contrast, use of the artificial heart, which is regarded as experimental and, therefore,

commonly not reimbursed, prolongs life for an average of more than 11 years with relatively few restrictions on lifestyle. Applying quality adjustments developed by consensus, he evaluated the cost effectiveness of artificial heart use at $113,800 per quality-adjusted life-year (QALY) compared to an exorbitant $950,000 per QALY for the conventional treatment. (A third mode, transplantation, is even more cost effective at $35,300 per QALY, but is less accessible due to the shortage of available organs.)

Another speaker at the conference, Governor Jim Florio, declared health reform "the cutting-edge issue of the 1990s." Governor Florio did not mention physicians directly, although he characteristically referred to the "vested interest" of "providers and insurance companies." He also remarked that the health care system is "strangling in red tape."

CLIA registration. As of September 1, 1992, physicians need a Clinical Laboratory Improvement Act (CLIA) identification number to be reimbursed by Medicare or Medicaid for clinical laboratory services. To obtain a CLIA form, contact Marge Bolling at MSNJ executive offices. For information call the AMA's CLIA hotline at 1/800/AMA-3211.

MALPRACTICE AND OTHER CASES

Retirement benefits exempt from creditors. In one of the last decisions of its October 1991 term, the U.S. Supreme Court ruled on June 15, 1992, that assets held in qualified pension or profit-sharing plans are exempt from creditors' claims in bankruptcy actions. The decision applied the federal Employee Retirement Income Security Act (ERISA), which incidentally is the same law used by a federal district court judge to strike down funding of New Jersey's uncompensated care trust fund.

Protected accounts include Keogh plans and other qualified retirement plans that, as ERISA directs, prohibit assignment of benefits. The high court's decision makes retirement plans more effective, in this regard, than individual retirement accounts (IRAs). But, both types of accounts would be exempt from creditors' claims in New Jersey under legislation now pending in the Assembly as A-1462, notes the Roseland law firm of Brach, Eichler.

The Court's unanimous decision was delivered by Justice Harry A. Blackmun. In a typically caustic concurring opinion, Justice Antonin Scalia decried the interpretation of the statutory phrase "applicable bankruptcy law" by three U.S. courts of appeal, all of which applied the phrase to state law. This "phenomenon" of interpretation, said Justice Scalia, "calls into question whether our legal culture has so far departed from attention to text, or is so lacking in agreed upon methodology for creating and interpreting text, that it any longer makes sense to talk of 'a government of laws, not of men.' " He added his hope that the Supreme Court decision is sufficiently clear that "the symbol of our profession may remain the scales, not the seesaw."

No liability for vaccination. Louisiana's Court of Appeals has reversed a trial court decision that imposed liability on a physician for failing to inform a family of a one-in-eight-million chance of contracting polio from an oral immunization. The appeals court decided that causation was not shown in the case involving an infant. The court further determined that no reasonable person would have refused the vaccine, as evidenced by the physician's experience of 9,100 acceptances and no refusals.

MALPRACTICE POLICY DEVELOPMENTS

Poll results support tort reform. An AMA poll, summarized in *Medical Liability Monitor*, shows that only 16 percent of family physicians now deny performing unnecessary tests in order to protect themselves from liability. This is a substantial rise in reported defensive medicine, as 25 percent of family physicians similarly reported in a 1989 poll. The AMA also found that 63 percent of the public believe that too many people sue for medical malpractice. ☐ James E. George, MD, JD; and Neil E. Weisfeld, JD, MSHyg

CORRECTION

In the August commentary, under the section, "Cardiac Catheterization and Stroke (page 568)," the second paragraph should read: "To help weigh the plaintiff's credibility, the New Jersey jury was permitted to learn that *he* currently was incarcerated for violating laws on controlled and dangerous substances. The jury found for the defendant."

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Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.[1,3,4] 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to ½ tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.[3]

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References:

1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical Letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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BOOK REVIEWS

HEALTH, DISEASE AND HEALING IN MEDIEVAL CULTURE

Sheila Campbell; Bert Hall; David Klausner. New York, NY, St. Martin's Press, 1992. This anthology originated from a conference held in Toronto in February 1989. The essays, dealing chiefly with the Christian West, highlight the interdisciplinary character of modern research in the history of medieval medicine. Surprisingly, for such a diverse collection, the research and writing are consistently good.

Several papers were enlightening. Drs. Voigts and Hudson write about dwale, an oral stupefactive drink used to relieve pain during surgery. Found in more than 30 late-medieval English manuscripts, dwale was composed of lettuce, wild nept (a purgative), hemlock juice (a dangerous ingredient not contributing to the anesthetic effect), swine gall, opium, and henbane (a purgative) in a wine vehicle laced with vinegar. This recipe is unique for its precise measurements and instructions for preparation. Importantly, details of administering dwale suggest an attempt to prevent overdosage, which was recognized as deadly. Another article, on French sickdishes, describes foods for people suffering from a delicate digestion or infirmity. Chicken was used in these recipes most often, because it was deemed readily digestible, nourishing, and well tolerated. This dietary counsel has a modern ring to it.

Of particular interest was Dr. Wortley's essay that equates the curative effects of holy relics with placebo effects. The anonymous author of the 12th century "Tale of the Converted Robber" reveals that he understood that reactions of a willing human psyche rather than divine intervention worked the miracles. Thus, the power of placebo was appreciated centuries before the advent of the double-blind trial.

All was not so scientific, of course, as evidenced by a chapter dealing with chanting of Hebrew psalms to aid healing in 13th century England. Roger Bacon, the Franciscan savant, embraced the use of such incantations to cure all manner of ills, because he believed that the wisdom of God was revealed in the Hebrew language.

Health, Disease and Healing in Medieval Culture dispells the common belief that our medieval forebears were universally credulous and irrational in medical matters. To the contrary, many showed sound judgment, gave practical advice, and had reasonable notions about the nature of disease. □ Vincent J. Cirillo, MS

HIPPOCRATIC LIVES AND LEGENDS

Jody Rubin Pinault. New York, NY, E.J. Brill, 1992. Hippocrates of Cos (c. 460-375 BC), venerated as the father of medicine, is a shadowy figure. We have little accurate information about his life. Most of what we know is derived from the *Vita Hippocratis*, attributed to Soranus of Ephesus, a physician who lived during the second century AD.

Hippocratic Lives and Legends originated from the author's doctoral dissertation in classical studies at the University of Pennsylvania. This book traces the development and historicity of four biographies of Hippocrates written between the 2nd and 12th centuries AD, and three legends dating from the 3rd century BC. The latter were so famous that

they found their way into Arabic gnomologia and biographies of Hippocrates, translated into English for the first time.

The legend of Perdiccas's love-sickness illustrated Hippocrates' diagnostic acumen. Perdiccas, King of Macedonia, was thought to be consumptive, but Hippocrates recognized that his affliction was psychic in origin. After the death of his father, Alexander the Great, Perdiccas fell in love with Phila, his father's mistress. Because of conflicting emotions and a sense of shame, Perdiccas's hidden passion manifested itself as a wasting disease. Although Perdiccas recovered, we never learn if they lived happily thereafter.

The story of Hippocrates curing the plague in Athens (430 BC) by kindling bonfires of fragrant wood throughout the city, demonstrated his skill in treatment. Since Egyptian times pestilence was fought with fire, because fire was believed to purify air so that it no longer was capable of causing harm when inhaled. Thus, Hippocrates' action was shaped by the established medical theories of the day.

The final tale describes Hippocrates' refusal of Artaxerxes' petition for help to combat an epidemic that was destroying the Persian army. It showcased Hippocrates' patriotism and ethical incorruptibility. Despite the promise of riches, he would not serve an avowed enemy of Greece.

Dr. Pinault's indepth analysis of these fictitious stories reveal that they satisfied a need in antiquity to display the professional skills and moral superiority expected of an exemplary physician. Hippocrates personified the ideal healer: "He constituted the stars and the light of the art of medicine." This need continues to be felt today, only we call it medical ethics. ☐ Vincent J. Cirillo, MS

IMAGING OF CARDIAC DISORDERS

Benigno Soto; E. George Kassner; William Baxley. New York, NY, J.B. Lippincott/Gower Medical Publishers, 1992. The imaging of cardiac disorders has been greatly enhanced in the last few years, with two-dimensional echocardiography and magnetic resonance imaging (MRI) offered among a growing choice of modalities. The authors of this two-volume set have kept pace with this topic and are to be acknowledged for their systematic approach to the subject.

The first volume begins with an overview of the technical aspects of cardiac imaging and encompasses a discussion of electrocardiograms, cardiac catheterization, and MRI. The principal part of the text consists of a methodical and readable examination of congenital abnormalities. Superb line drawings help illustrate the embryology of each disease state. The authors then study the imaging modalities, presenting examples of plain films, ventriculograms, and a variety of scans, including echocardiograms. As the volume concludes, special attention is devoted to postoperative patients. This well-composed section covers the radiological evaluation of a wide array of surgical and transcatheter techniques.

The second volume centers on acquired cardiac diseases. Interestingly, the authors repeat the first volume's opening overview of the technical aspects of cardiac imaging. Valvular, ischemic, and pericardial disorders compose the mainstay of this second half of the set, and the format mirrors that of the first volume. An exhaustive review of plain film and cine appearance of prosthetic valves is found in the chapter discussing the latest therapeutic techniques. The text is full of first-rate illustrations and excellent descriptions, providing a succinct presentation of each topic. The result is a state-of-the-art reference of the field. ☐ Neil B. Horner, MD

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LETTERS AND VIEWPOINTS

SILICONE-GEL BREAST IMPLANTS

I am writing with compliments for the excellent editorial in the June 1992 issue concerning silicone-gel breast implants. I have been practicing plastic and reconstructive surgery in New Jersey for 25 years. There is no question that the overwhelming majority of our reconstruction and breast augmentation patients who have received silicone-gel implants are happy with the results. As you pointed out quite well, the garbled message of the Food and Drug Administration (FDA), and the media-induced hysteria has produced considerable self-doubt and unhappiness in many patients with otherwise excellent results. It is not unusual for patients from many years ago to call now and say, "I feel fine, should I be worried?" I and many of my plastic surgery colleagues recall such patients, at no charge, to re-examine and counsel them in the office. We give these patients copies of the current reports from the FDA and from the American Society of Plastic and Reconstructive Surgeons. We also give them copies of the recent pronouncements from the American College of Rheumatology, which state that there is no medical evidence for a reported connection between silicone-gel implants and "immune diseases."

One aspect of this entire FDA-precipitated fiasco is that there now is a nationwide epidemic of lawsuits arising, encouraged by the national legal societies. Through media advertising, any woman with any implant with any physical complaint is encouraged to call "1/800/IMPLANT" or to join an Ohio class-action suit or otherwise contact her local attorney. While most of these attacks are against manufacturers, some attacks now are being extended against individual plastic surgeons. Despite the lack of proof associating gel-filled mammary implants with any known disease, litigation is being encouraged. The door also is open for all other silicone products in the body, including hydrocephalus shunts, silicone joints, heart valves, and jaw implants. I am waiting to see when silicone-coated hypodermic needles and syringes and suture material will be hyped in the press as well.

Thank you again for drawing attention to this important issue. ☐ Richard B. Bloomenstein, MD

Editor's note. Since our editorial, many publications, led by *The New England Journal of Medicine*, have expressed similar sentiments. Would reconsideration by the FDA be in order?

PROs

In the July 1992 issue of *NEW JERSEY MEDICINE*, there was an article by Drs. Kingsley and Rodi of The PRO of New Jersey, Inc. (NJ MED 89:527-528, 1992). The essay extolled the virtues of The PRO and urged physicians to support the organization in opposition to proposed regionalization of the screening process.

The authors are correct in pointing out that peer review organization (PROs) need to change their emphasis from judgmental and punitive to educational. Many practicing physicians feel that PROs epitomize the "hassle factor" and unfairly have targeted and sanctioned competent physicians, destroying lives and careers in the process. The tragic suicide of Dr. William Difenbach has been cited as an example. After a career spanning 30 years of service to patients, Dr. Difenbach was expelled from the Medicare program for what essentially was a recordkeeping issue.

The statement by Dr. Kingsley and Dr. Rodi declaring that "nursing judgment" and that of "medical records professionals" are essential and desirable in physician review is arguable. Touted as a strength of the current system, many physicians would argue to the contrary.

Their belief that the current system assures quality review also can be questioned. In a 1988 study, we found that independent reviewers disagreed frequently with the judgment of PRO reviewers.

The issue of confidentiality also is raised by their belief that regionalization would compromise it. Somehow the current system of nurses and "medical records professionals" peering through charts does not inspire confidence that our privacy is protected.

It is ironic that after a decade of alienating physicians and engendering our animosity, The PRO of New Jersey, Inc. now asks for our support. Hope truly does spring eternal. ☐ Michael A. Patmas, MD

EDITOR'S DESK

ADVERTISING

A headline in *American Medical News (AMN)* of June 15, 1992, asked, "Who should police drug ads?" The article referred to a study in the June 1 issue of the *Annals of Internal Medicine* entitled, "Pharmaceutical Advertisements in Leading Medical Journals: Experts' Assessments" by Wilkes, Doblin, and Shapiro, that concluded, "In the opinion of the reviewers, many advertisements contained deficiencies in areas in which the Food and Drug Administration (FDA) has established explicit standards of quality. New strategies are needed to ensure that advertisments comply with standards intended to promote proper use of the products and to protect the consumer." The reviewers, two physician clinicians, and an academic clinical pharmacist, found very few advertisements acceptable at face value.

The authors suggested, with variable enthusiasm, several potential methods of correcting the avowed problems. A ban of drug company advertising in medical journals was mentioned but considered unworkable and likely to lead to more nefarious uses of company promotional funds. Greater federal involvement was deemed more advisable, to include approval of advertisements before publication, the imposition of more severe penalties for infractions, and greater personal involvement by the journals and professional organizations. Among the more interesting comments was the following: "It is not certain that journals would ever subject advertisements to a truly rigorous review process unless there were incentives for them to do so; such incentives might take the form of fines for publishing advertisements not meeting a specified standard." (Whose standards? The ones established by the same government that allows advertisements for butts and booze?)



Howard D. Slobodien, MD

In obvious anticipation of the potential fallout from this article, the editors of *Annals,* Drs. Robert and Suzanne Fletcher, invited a guest editorial from Dr. David Kessler, head of the FDA, and then wrote their own critique.

Dr. Kessler felt the study "serves an important purpose. It heightens awareness of the degree to which misleading information may provide the 'informational marketplace' underlying physicians' prescribing decisions .... Advertisements of prescription drugs present problems that are not encountered in advertisements for other products." (But he did not delineate the differences.) He conceded that promotional materials, by law, must be based on the package inserts that are researched so carefully and approved only after meeting the rigorous standards of the FDA. But he also felt that the average physician lacked the skills to be able to evaluate the claims of drug efficacy. He also explained that the FDA's Division of Drug Marketing, Advertising, and Communication had begun a project in October 1991 to identify the statistical defects in the clinical claims of drug manufacturers. If the two examples he cited of this new study are representative of the types of misrepresentation that are beyond the ken of practicing physicians, he has much to learn about the true capabilities of all of us. Although Dr. Kessler conceded that the FDA had intensified its activities (and he has certainly been given more bodies to do the work), he said the FDA could not do the job alone and needed help from us and from the drug manufacturers.

Drs. Robert and Suzanne Fletcher, who accepted the article for publication, apparently also accepted the validity of the study. To their credit, they delineated the basic differences between scientific articles and advertisements. The former are "written to inform and educate, perhaps even to entertain," while the advertisements, all $352 million worth of them, are designed to persuade us to prescribe the products advertised. They also noted that the advertisements are reviewed by the same types of individuals who might review scientific articles and not by people more knowledgeable of the acceptable parameters of the advertising business. But they published the article. We would not have published it. In addition to the warranted criticism of the type of reviewer noted by the Fletchers, the criteria for acceptability of the

advertisements is much too stringent, thereby weighting the conclusions improperly; the tables are misleading, and the totals in the tables do not compute.

The editors of *Annals* explained how they attempt to control their advertisers and their messages. Most of their guidelines regard the number and placement of advertisements, and these are the policies of many other journals, including *NEW JERSEY MEDICINE.* Although they agreed with the need for additional scrutiny, they conceded that budgetary restrictions prevent most medical journals from expanding their roles. What is needed, they said, is a "larger, multidisciplinary review body ... in the United States." If this could be done without adding to bureaucracy—a debatable premise—it is worth considering. And finally, as a breath of fresh air, they stated, "Critical readers are the last line of defense against misinformation of any kind." In other words, maybe physicians are caring enough to try to sift available information in ways to benefit their patients. (We could have told them that without having to review flawed pseudoscientific articles.) It should also be noted that *JAMA* and *The New England Journal of Medicine,* as reported in *AMN,* do not routinely monitor advertisements.

The New York Times of July 22, 1992, noted that "*Trial,* a publication of the Association of Trial Lawyers of America (ATLA), refused to publish an advertisement for *The Litigation Explosion: What Happened When America Unleashed the Lawsuit,* by Walter K. Olson." The public relations director for ATLA said the advertisement was rejected because it did not have enough "interest and usefulness" for the readers of *Trial* and because studies by various other groups tended to refute the validity of Mr. Olson's conclusion. Conversely, the American Bar Association accepted the book advertisement for the *A.B.A. Journal* and *The Student Lawyer* likewise was happy to accept the advertisement "and the nearly $1,000 in revenues," in essence allowing the readers to "decide for themselves how to respond to an advertisement for the book—by, for example, buying the book, ignoring the advertisement, or even burning it," as expressed by *The Times.*

Our policy regarding the acceptance or rejection of advertisements tends to follow those of the *Annals of Internal Medicine,* especially the one that attempts to insure a lack of offensiveness or bad taste. (And we invite our audience to read the original editorial in *Annals* for details.) However, we do not follow *Annals'* decision to place all advertisements in the front and the back of the journal. As long as the copy is easily distinguishable from scientific and other editorial materials and does not interrupt the reader's attention to a specific article, it seems more equitable to intersperse the advertisements throughout the journal so that the ones paying the advertising freight have a reasonable chance of having our readers at least note their materials. We also decry the attitude of ATLA; we have printed, and will continue to accept, acceptable advertising from groups that may oppose us in certain spheres, e.g. the insurance company that competes with the Medical Inter-Insurance Exchange sponsored by the Medical Society of New Jersey.

We must give heartfelt thanks to Thomas Hegyi, MD, guest editor, and his contributors for this special issue devoted to sudden infant death syndrome (SIDS). There is much to be learned from these articles even though, of course, much still remains uncovered. For those of us whose children are grown and who are enjoying the next generation, at least one of the recommendations from the American Academy of Pediatrics gives us pause—to put infants on the back or side, not on the abdomen, in order to decrease the chances of SIDS. As we said, thank goodness our children are grown, because some old habits die hard. □

Howard D. Slobodien, MD

The deeper problems connected with advertising come less from the unscrupulousness of our "deceivers" than from our pleasures in being deceived, less from the desire to seduce than from the desire to be seduced.

Daniel J. Boorstin,
The Image or What Happened to the American Dream (1962)

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PRESIDENT 'S PAGE

COPELAND VERSUS SULLIVAN

On a cold winter's night, many months ago, I journeyed to the Ho-Ho-Kus Inn in Bergen County. Along with other Medical Society of New Jersey (MSNJ) members, I listened to a presentation by Dr. Lois Copeland, a Bergen County internist, and her counsel, Kent Masterson Brown, concerning a proposal to "opt out" of the Medicare system. Dr. Copeland outlined the many frustrations of physicians and patients in dealing with the current Medicare program. Was there a way for men and women to contract out of Medicare? Mr. Brown felt the first section of the Medicare act entitled, "Prohibition Against any Federal Interference," allowed such a relationship.

The Medicare law states that "nothing in the Medicare act shall be construed to authorize any federal official or employee to exercise any supervision or control over the practice of medicine or the manner in which medical services are provided, or over the . . . compensation of any . . . institution, agency, or person providing health services."

Dr. Copeland and Mr. Brown outlined a plan for bringing action in federal district court. Specifically, Dr. Copeland and five patient-defendants would be plaintiffs in a lawsuit in which a legal opinion would be sought on the issue of whether or not plaintiff-patients could privately contract with their physicians outside the Medicare program for services, provided no bill was rendered to Medicare.

On January 31, 1992, a filing was made to hear arguments before U.S. district court Judge Nicholas Politan in Newark. The case will be heard on September 14, 1992, in Newark.

At its annual meeting, MSNJ endorsed the position of Dr. Copeland and charged the AMA delegation to bring this position to the AMA House of Delegates. This was accomplished in Chicago; as a result, the Board of Trustees of the AMA authorized the firm of Sidley and Austin to enter amicus in the case. The AMA and MSNJ filed the amicus brief on July 15, 1992. It is a document that sets forth patient and physician interests. It states, "Amici's interest in this case is to support the right of physicians and patients to make reasonable, private fee arrangements for the provision of medical services without undue interference by the federal government." The amicus argues that "under 42 U.S.C. No. 1395, the secretary may not interfere with a particular type of compensation arrangement unless Congress has specifically authorized such an interference." (It has not.) It further argues that the secretary's policy of opposing "opt out" violates congressional guarantee of freedom of choice of medical providers and causes unnecessary expenditures of federal funds. Interestingly, it points out that the federal government will save money if people pay out of pocket for medical care and do not use federal funds.

Further, the argument is made that the government's position is not supported by the physician claim submission provision or the limiting charge provision of OBRA 1989. Medicare requirements do not address "opt out" in which no claims are submitted. When no Medicare claim is made, a physician is not required to complete and submit a Medicare form.

One of the principal federal concerns is that "opt out" will lead to increased charges. However, quoting from the current *Code of Medical Ethics* of the AMA and the State Board of Medical Examiners' position on excessive fees, physicians clearly are limited in what they can charge in the free market system.

There are those who feel that even winning the case will be of little benefit to physicians since the number of patients who might "opt out" may be minuscule. After all, what patient would leave a program that is relatively comfortable to venture into an unknown and open market to solicit services from physicians?

There may be more people than one would think. As Medicare becomes more restrictive in access and services, more and more seniors might find this "opt out" arrangement more fluid, expeditious, and hassle free.

"Opt out" may catch on and be modified; perhaps it will lead to a practice outside of Medicare that is enjoyed in other countries. "Opt out" certainly will serve as a safety value and an alternative to the current Medicare program.

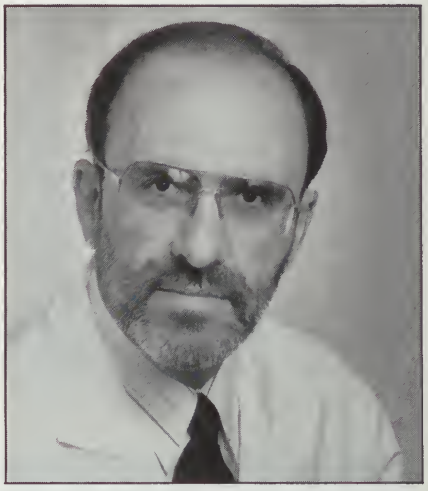
The biggest impact of this case will be that it puts Washington, DC, on notice that physicians and patients find the Medicare program too onerous and too complex, and prefer some alternative. The monolith would be broken and more attention would have to be paid to patient and physician satisfaction.

I sincerely applaud Dr. Copeland and her co-plaintiffs. MSNJ and the AMA wish them well. ☐ William E. Ryan, MD

Sudden infant death syndrome in 1992: The known and unknown

Thomas Hegyi, MD

Sudden infant death syndrome (SIDS) continues to be the leading cause of death in infants from one month to one year of age. We present the results to the Fifth Annual Perspectives on SIDS. This program is one component of the educational services of the New Jersey SIDS Resource Center.



Thomas Hegyi, MD

Since the Second International Conference in 1969,[1] sudden infant death syndrome (SIDS) has been defined in the United States and Canada as the "sudden death of an infant under one year of age that remains unexplained after a thorough case investigation, including performance of a complete autopsy, examination of the death scene, and review of the clinical history."[2] In spite of a decline in infant mortality in the United States, to a provisional rate of 9.7 per 1,000 live births in 1989, the SIDS death rate of 1.4 per 1,000 births represents an increase from the previous year.[3] SIDS, thus, remains the most common cause of death in infants between one month and one year of age.[4]

Epidemiologic studies of SIDS victims have identified populations at higher risk for death, including premature infants, infants who have experienced a severe, apparent life-threatening event (ALTE), and subsequent siblings of SIDS victims. The increased SIDS risk in preterm infants correlates with birthweight with an incidence for infants weighing less than 1,500 grams to be 10 per 1,000 live births.[5,6] An ALTE is frightening to the observer and characterized by apnea and color change (cyanosis or pallor, occasionally erythematosus or plethora), hypotonia, choking, or gagging.[7] Apnea of infancy refers to a subgroup of infants whose ALTE was idiopathic and believed to be related to apnea[7]. The incidence of SIDS in this group ranges between 6 and 28 percent, depending on the recurrence of subsequent episodes and the need for vigorous stimulation.[8] The SIDS risk in subsequent siblings varies from a 20/1,000 incidence in families with a single occurrence[9] to a 180/1,000 incidence when 2 or more previous SIDS deaths have occurred.[10]

Additional medical and demographic characteristics have been implicated in SIDS risk, with the most recent example being prenatal drug exposure.[11] Racial differences are manifested as the relative risk for black infants is fourfold and the relative risk to native American infants is 3.5 times that of white infants.[12,13]

Unfortunately, the demonstration of high-risk characteristics has not shed light on the pathophysiology of the disorder. The most favorable current hypothesis implicates brain stem abnormalities in controlling breathing, and is based on observations in infants at increased risk for SIDS: increased frequency of brief inspiratory pauses,[14,15] prolonged sleep apnea,[16] excessive periodic breathing,[17] obstructive apneas,[18,19] elevated tachycardia index,[20] and diminished ventilatory and arousal responses to hypoxia or hypercapnia.[21-25] There are contradictory results for all or some of the listed abnormalities in the literature,[26,27] and, thus, the etiology of SIDS remains elusive.

Another area of investigation has been gastroesophageal reflux due to defective functioning of the lower esophageal sphincter, which is common in many high-risk infants.[28-32] Respiratory problems caused by reflux are due to reflex laryngospasm from stimulation of laryngeal chemoreceptors or aspiration of gastric contents.

Recently, a metabolic disorder has been implicated as the cause of death in some infants misdiagnosed as SIDS. Medium chain acyl-coenzyme A dehydrogenase deficiency (MCADD) is a diagnosable autosomal recessive error of fatty acid metabolism that can be fatal in infancy. Its incidence rate has been estimated to be among the highest of inborn errors of metabolism. The mortality rate in the first manifestation of the disorder is 59 percent; often the infant has been asymptomatic.

Despite the identification of specific high-risk groups, and the available technologies for the documentation of cardiorespiratory abnormalities, no study to date has yielded any prospectively determined and clinically useful differences between control infants and later SIDS victims.[15,19,33,34] Since the early 1970s, home monitors have been employed in the United States, with at least 40,000 to 45,000 estimated to be in use at any one time.[7] Due to a number of factors that include population heterogeneity, differing protocols, and unreliability of equipment, no data are available confirming reduction in SIDS rates due to home monitoring.

One area of imprecision is parental unreliability in reporting observations.[25] The new technology of documented monitoring provides the solution for accurately observing the events during and surrounding true perturbations of cardiorespiratory control. This monitor, a combination of an event recorder and home monitor, maintains a continuous updating memory of cardiac and respiratory signals. Whenever the preset limit for the monitor has been exceeded, the preceding interval, the event, and the recovery interval are recorded along with the date and time of each episode. A hard copy generated from these events permits hand scoring and interpretation. Therefore, the objective interpretation of home alarms has become feasible with the combination of these monitors with parental logs.

This issue of *NEW JERSEY MEDICINE* provides reviews on areas of SIDS as discussed at the recent Fifth Annual Perspectives on SIDS. The conference is one component of the educational and counselling services of the New Jersey SIDS Resource Center (NJSRC). This program is funded by the New Jersey State Department of Health to meet the needs of SIDS families and their providers. Dr. Michael Bennet, who has made key contributions to the understanding and diagnosis of MCADD, relates the material he presented in his medical keynote address. An overview of psychosocial issues surrounding sibling bereavement is presented by Donna Gaffney. Dr. Carbone presents the latest information on siblings of SIDS infants. A profile of SIDS in New Jersey, derived from the database maintained by NJSRC, is discussed by Tara Ryan. Dr. Barbara Ostfeld reviews the needs of families and physicians victimized by SIDS and the responsive services provided by NJSRC. Dr. Anne Koons tracked the long-term outcome of high-risk infants and presents these data. Dr. Michael Graff offers an overview discussion of the state of the art of SIDS. ■

Dr. Hegyi is director, New Jersey SIDS Resource Center; co-director, Division of Neonatology, St. Peter's Medical Center; professor of pediatrics, UMDNJ-Robert Wood Johnson Medical School; and director, New Jersey MCADD Education Project. Address reprint requests to Dr. Hegyi, UMDNJ-New Jersey Medical School, St. Peter's Medical Center, 254 Easton Avenue, New Brunswick, NJ 08903-0591.

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Sudden infant death syndrome in New Jersey: 1991

Tara Ryan, RNC, BSN
Barbara Ostfeld, PhD
Pamela Buckalew, RN, MSN, CS
Thomas Hegyi, MD

Sudden infant death syndrome (SIDS) is the leading cause of death in infants one month to one year of age. The New Jersey Sudden Infant Death Syndrome Resource Center gathers epidemiological data on all SIDS deaths in New Jersey, noting differences in population and counties.



Tara Ryan, RNC, BSN



Pamela Buckalew, RN, MSN, CS

Sudden infant death syndrome (SIDS) is the leading cause of death in infants one month to one year of age.[1] In New Jersey, only complications related to prematurity and birth defects rank above SIDS as the leading cause of death in all infants in this age category. SIDS leaves its devastating mark on approximately 100 to 132 families in the state annually. In 1990, the SIDS rate for New Jersey was 0.91/1,000 infants, falling below the latest national estimated rate of 1.29/1,000 infants.[2] This article reviews SIDS in New Jersey for 1991.

The New Jersey SIDS Resource Center (NJSRC) received 120 referrals of sudden infant death last year. Referral sources included medical examiners (72, 60 percent); New Jersey State Department of Health (17, 14 percent); hospitals (9, 8 percent); other SIDS centers (6, 5 percent); SIDS Alliance, New Jersey Affiliate (5, 4 percent); and other sources such as the Department of Youth and Family Services, apnea programs, and family (11, 9 percent). Ostfeld examined the reliability of the preliminary SIDS diagnosis and identified specific categories that challenged



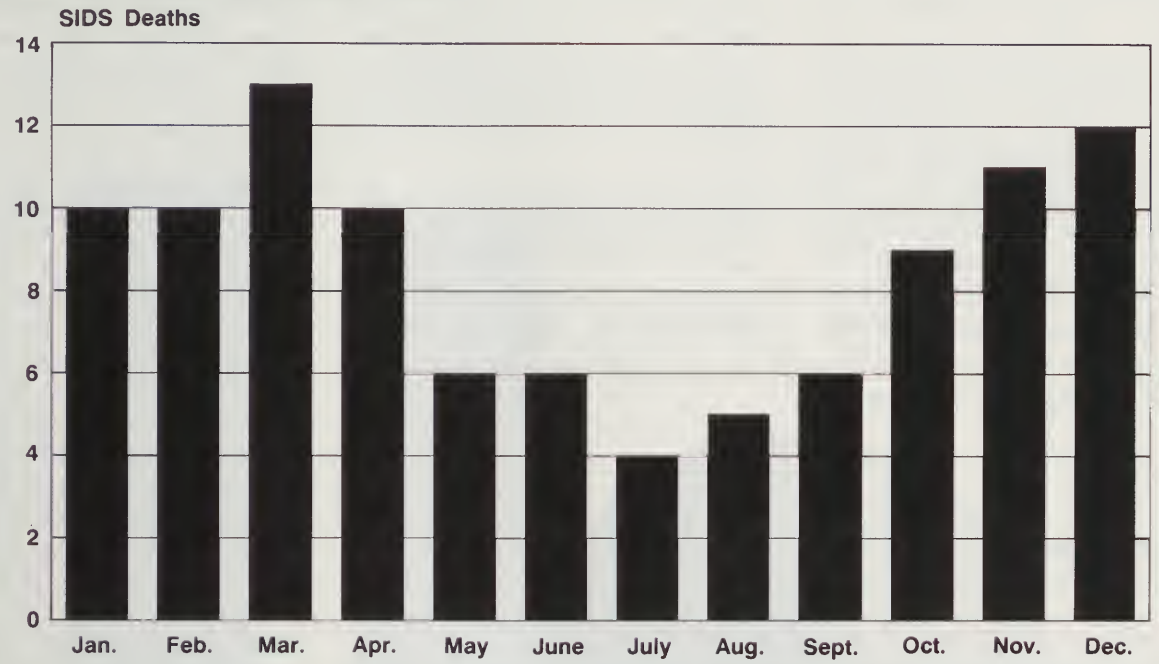
Barbara Ostfeld, PhD

the differential diagnosis established clinically. The preliminary diagnosis was substantiated in 84 percent of the 295 cases examined. Diagnoses changed most frequently were diseases of the respiratory system.[3] Of the cases referred to NJSRC in 1991, 18 cases (15 percent) were finalized as a non-SIDS diagnosis. The most common diagnoses were respiratory infections (41 percent) and cardiac conditions such as myocarditis and cardiomyopathy (23.5 percent). Other diseases included positional asphyxia, meningitis, CMV, Reye's syndrome, sepsis, trisomy 5, and possible homicide.

SIDS rates are noted to fluctuate with the seasons, with the largest number of deaths occurring during the coldest months. In 1991, SIDS deaths peaked between the months of October and January. July represented the lowest month with four deaths (Table 1).

Distribution of deaths by county also followed a typical pattern

Table 1. *SIDS by month, 1991.*

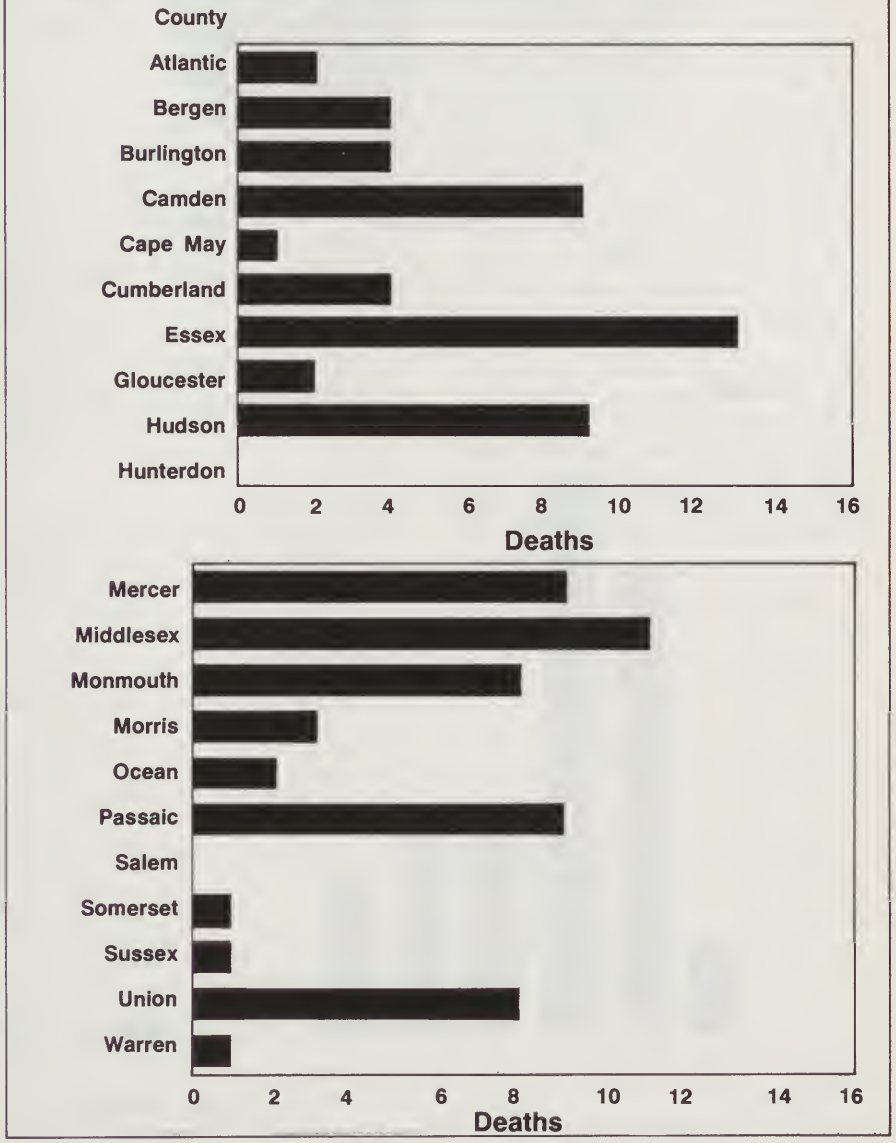


for the state with those counties with large inner-city populations experiencing the highest number of SIDS deaths. There were 13 deaths in Essex County, followed by 11 deaths in Middlesex County, and 9 deaths each in Hudson, Camden, Mercer, and Passaic Counties. No SIDS deaths were reported in Hunterdon and Salem counties (Table 2).

Certain maternal risk factors have been identified to be associated with an increased incidence of the syndrome.[4] These include maternal age, no prenatal care, smoking, substance abuse, and complications during pregnancy. The mean maternal age in New Jersey was 24.7 years; however, the majority of cases was seen in the younger age groups with mothers in the 15-to-19-year age group experiencing 25.4 percent of all the deaths (Table 3). Smokers accounted for 45.2 percent of the population. Hypertension was reported by 21.4 percent, anemia was reported by 21.4 percent, and absence of prenatal care was noted by 8.95 percent.

Conflicting reports exist as to the relationship between SIDS and cocaine use during pregnancy.[5,6] Nineteen percent of the mothers admitted to substance

Table 2. *SIDS in New Jersey, 1991.*



abuse during pregnancy, cocaine being the most frequently used drug.

The SIDS literature reports the greatest number of SIDS victims in the two-to-four month range.[1] Fifty-five percent of infants fell into this bracket, with 96 percent of the deaths occurring by six months of age. The mean age of death was 11.8 weeks (Table 4). SIDS is typically more common in male infants who comprised 58 percent of the SIDS cases in the state this past year. Black infants have an almost threefold chance of dying of SIDS.[1] Breakdown of deaths by race is shown in Table 5.

Premature infants are at greater risk to experience SIDS.[1] While premature births account for approximately 6 percent of live births, in the SIDS population this group represented 19 percent of the deaths. The mean gestational age was 38.3 weeks and mean birth weight was 2,970 grams, with 12.1 percent falling below 2,000 grams.

In the New Jersey population, 44.4 percent of the families reported symptoms of minor illness in the weeks prior to death. Gastrointestinal problems such as vomiting, diarrhea, and formula intolerance were noted in 7.9 percent of SIDS cases. Parents indicated that 14.3 percent experienced noisy breathing, and 7.9 percent reported at least one apnea prior to death. One infant died while on an apnea monitor. This infant was born at 26 weeks' gestation, had moderate bronchopulmonary dysplasia, and a history of apnea prior to death. One sibling of a SIDS infant (19 years ago) died but was not monitored.

SIDS remains a disease that does not discriminate among its victims. The tragedy remains in the inability to identify SIDS infants and to prevent this devastating loss. ■

Table 3. *Age of mother, 1991.*

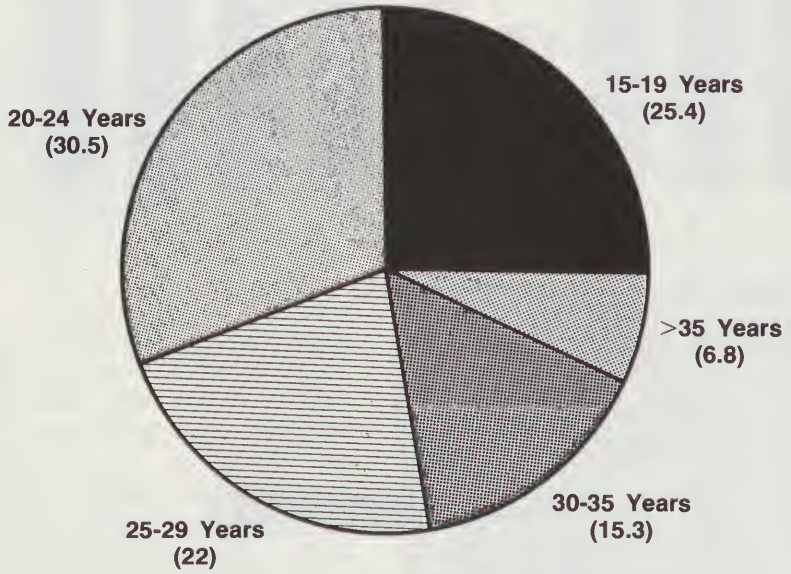


Table 4. *Age at death, 1991.*

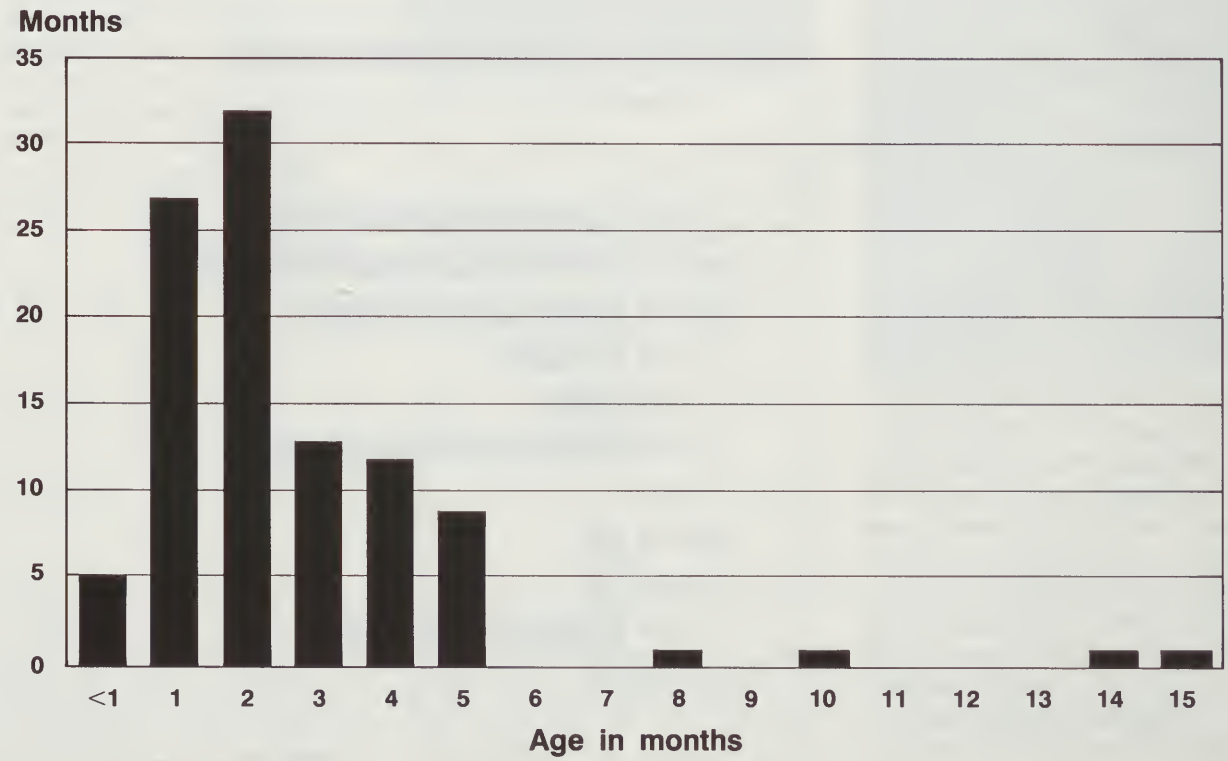
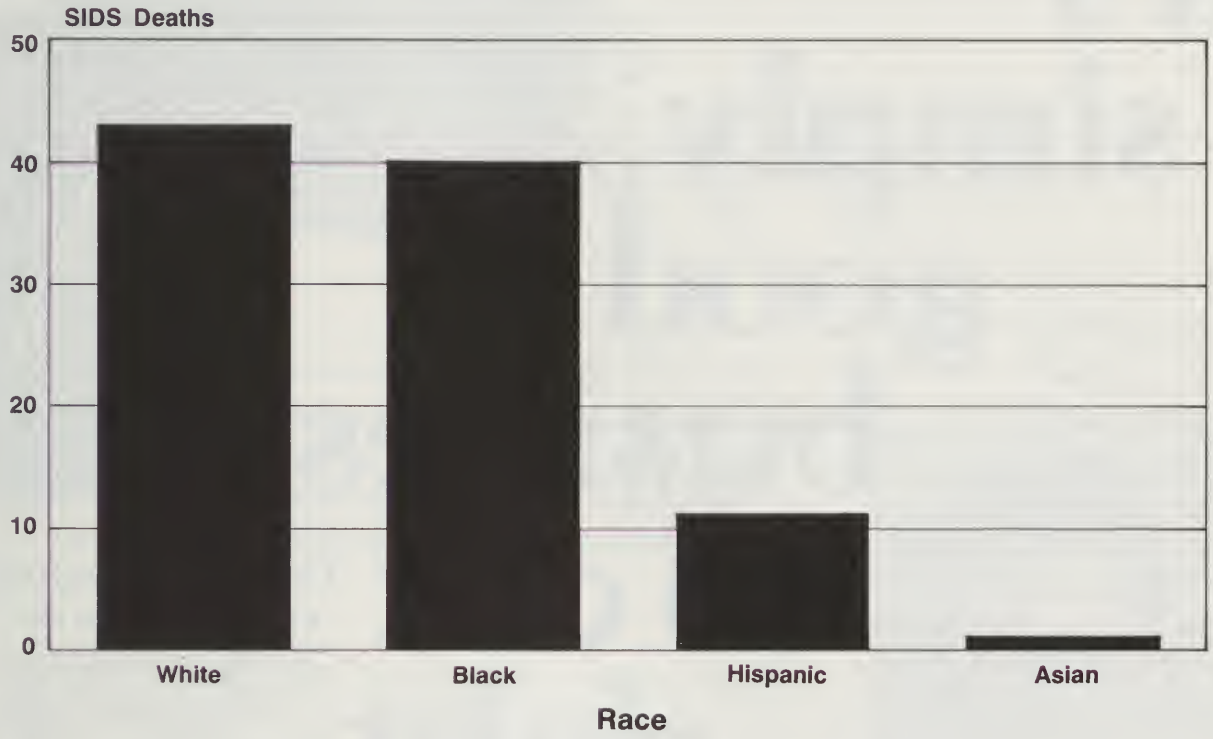


Table 5. *SIDS by race, 1991.*



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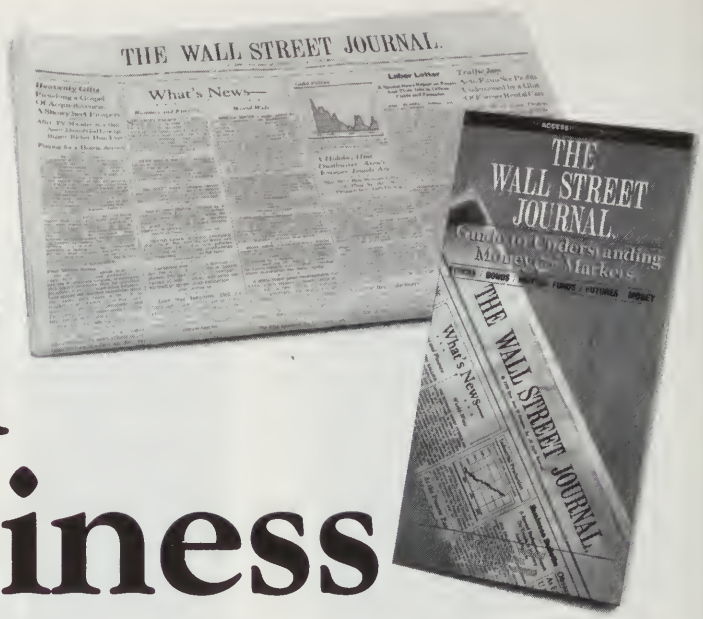
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Ms. Ryan is acting coordinator, New Jersey SIDS Resource Center. Dr. Ostfeld is associate director, New Jersey SIDS Resource Center, director of pediatric psychology, St. Peter's Medical Center, and clinical associate professor of pediatrics and psychiatry, UMDNJ-Robert Wood Johnson Medical School. Ms. Buckalew is SIDS outreach nurse, New Jersey SIDS Resource Center. Dr. Hegyi is director, New Jersey SIDS Resource Center, co-director, Division of Neonatology, St. Peter's Medical Center, and professor of pediatrics, UMDNJ-Robert Wood Johnson Medical School. Address reprint requests to Ms. Ryan, New Jersey SIDS Resource Center, 254 Easton Avenue, New Brunswick, NJ 08903.

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Medium chain acyl-coenzyme A dehydrogenase deficiency

Michael J. Bennett, PhD
Daniel E. Hale, MD

Medium chain acyl-coenzyme A dehydrogenase deficiency (MCADD) was the first metabolic disorder found to be associated with sudden infant death syndrome. This review covers recent advances in the biochemical and molecular understanding of MCADD.



Michael J. Bennett, PhD

Medium chain acyl-coenzyme A (CoA) dehydrogenase (MCAD) is one of approximately 20 enzymes involved in the mitochondrial β-oxidation of straight chain fatty acids. Although the principle of β-oxidation pathway was first realized in the early part of the 20th century, delineation of the properties of the various enzymes has been hampered due to the lack of basic research.[1] However, in the last decade there has been an upsurge of knowledge, primarily arising from the realization of the broad clinical spectrum of genetic defects in the pathway. This ranges from symptomatic hypoglycemia through a Reye-like illness to sudden and unexpected death in infancy, including sudden infant death syndrome (SIDS). MCAD was the first enzyme to be described in detail and much of our knowledge of the metabolic, molecular, and clinical details of the pathway arises out of our understanding of this enzyme. This review, therefore, will focus on recent progress in MCAD and its deficiency with a particular emphasis on its role in SIDS.[2,3]

Catalytic properties of MCAD. MCAD catalyzes the initial reaction in the β-oxidation cycle. The reaction involves the dehydrogenation of medium chain fatty acyl-CoA compounds with the resulting product being a 2-3-enoyl-CoA compound (Figure 1). The chain length specificity of purified rat MCAD is for fatty acyl-CoA's of chain lengths C_4 (butyryl-CoA) to C_{12} (dodecanoyl-CoA) with optimal activity at C_6 (hexanoyl-CoA).[4]

Synthesis and mitochondrial transport of MCAD. The nuclear gene encoding human MCAD has been localized to the short arm of chromosome 1 (1p31)[4] and the full length cDNA sequence has been published.[5,6] The coding region is 1263 base pairs in length and encodes a precursor protein of 421 amino acid residues. Synthesis is on free cytoplasmic polysomes and the precursor enzyme has an approximate molecular weight 47KDa.[7] Following transport to the mitochondria, the precursor leader sequence is recognized, presumably by a specific receptor, and the mature protein subunit of approximately 43 KDa is transported into the mitochondrial matrix with loss of the 4KDa leader sequence.[7,8] Within the mitochondrial matrix, the active enzyme is assembled as a homotetramer of molecular weight of approximately 172KDa. The active enzyme has one molecule of flavin adenine dinucleotide (FAD) per monomer. The enzyme has been purified from pig liver and the three-dimensional structures of monomeric MCAD and the homotetramer have been revealed by x-ray diffraction techniques[9,10] that revealed the putative active site and FAD binding site.

Metabolic significance of fatty acid oxidation: Response to fasting and increased energy demand. The fatty acid oxidation pathway represents a significant energy-generating source in response to prolonged fasting or increased energy demand due to infection. Lipid stores become mobilized in order to preserve glucose as an energy source for obligate carbohydrate-requiring tissues, such as brain, in response to

Table. *Laboratory investigation of MCADD.*

Blood	Acute Presentation	When Well
Glucose	Low	Normal
Fatty acids	High	Normal
Ketones	Normal to High	Normal
Ratio fatty acids/ketones	Very High	Normal
Total carnitine	Low-Normal	Low
Esterified carnitine ratio	High	High
Cis-4-decanoic acid[1]	High	High
Urine		
Dicarboxylic acids	Very High	Normal
Acyl-glycines[1]	High	High
Octanoylcarnitine[1]	High	High

[1]Requires sensitive mass spectrophotometric analysis.

glycogen depletion. There is subsequent channeling of fatty acids to tissues that can utilize them as an alternative energy source, in particular liver and muscle. In liver, the end products of fatty acid oxidation are ketone bodies that also are used as an alternative cerebral energy source in addition to glucose. In muscle, the fatty acids are oxidized entirely to carbon dioxide and water.

MCAD deficiency, clinical spectrum. In 1976, Gregersen published the case of a Danish patient who presented with a recurrent Reye-like illness with the urine containing the unusual chemical, suberylglycine.[12] This patient and two other Danish patients who presented with symptomatic hypoglycemia subsequently were shown to have MCAD deficiency (MCADD).[13,14] The methodology required to confirm the diagnosis of MCADD was described in the early 1980s and a number of groups reported enzyme confirmation of MCADD in patients who had the presentation of a Reye-like illness. These patients also were observed to have nonketotic hypoglycemia, hyperfatty acidemia, and hypocarnitinemia.[15-18]

SIDS was first diagnosed in a patient shown to have MCADD in 1984.[19] Subsequently, there have been other reports of MCADD occurring in SIDS populations.[20-24] A detailed study of the first 100 enzyme-confirmed cases of MCADD in Dr. Hale's laboratory revealed that there had been a previous sudden death (frequently attributed to SIDS) in 20 percent of the cases and that an equal number of infants died with the diagnosis of sudden unexpected death. These observations have given rise to much of the recent interest in the relationship of MCADD and SIDS. Interestingly, there also is an increasing number of reports of normal, clinically unaffected individuals with MCADD in families where siblings have died with either a Reye-like illness or SIDS.[21,22,25] This suggests that the disorder requires a secondary precipitating factor such as prolonged fasting, or a concurrent infection before the clinical phenotype is expressed. More importantly, this indicates that the prevention of fasting is an effective means of treating MCADD.

Biochemical abnormalities; symptomatic patients. Metabolic abnormalities in acute symptomatic MCADD arise out of the hepatic failure to convert fatty acids to ketone bodies, and of muscle to fully oxidize fatty acids. This results in the failure to preserve glucose as a cerebral energy source, and the accumulation of unmetabolized metabolic intermediates, and their byproducts. Fatty acids presented to the mitochondria for β-oxidation primarily are of long chain length, e.g. C_{16} and C_{18}. Palmitate (C_{16}), for instance, once activated to its CoA ester can undergo two cycles of β-oxidation releasing two moles of acetyl-CoA per mole of fatty acid. At the C_{12} level (dodecanoyl-CoA), the cycle cannot progress further in MCADD. A number of alternate metabolic routes are available to try to dispose of accumulating dodecanoyl-CoA. These routes are shown in Figure 2. As CoA esters cannot be transported across membranes, dodecanoyl-CoA may be converted to dodecanoyl carnitine for export out of the mitochondria. In the microsomes it may be subjected to ω-oxidation to form the respective dicarboxylic acid, dodecanedioic acid. This then can undergo limited peroxisomal β-oxidation to form the major excreted dicarboxylic acids adipic (C_6), suberic (C_8), and sebacic (C_{10}) acids. Suberic and hexanoic acids also may undergo glycine conjugation presumably as a mitochondrial process, to form suberyl- and hexanoylglycines, respectively. Octanoic acid and hexanoic acid also may undergo microsomal ω-1 oxidation to form 7-hydroxyoctanoate and 5-hydroxyhexanoate, respectively. Carnitine conjugation, in addition to being the major mechanism for removing acyl groups from within the mitochondria, also is a significant means of excreting accumulated intermediates as there also is urinary excretion of carnitine esters of accumulated fatty acids, in particular octanoyl carnitine. Thus, the detection of this wide range of urinary metabolites in a patient with hypoketotic, hyperfatty acidemic, hypoglycemia is a strong indicator of MCADD. Recently, Rinaldo described another novel metabolite found to accumulate in urine in MCADD. 3-phenylpro-

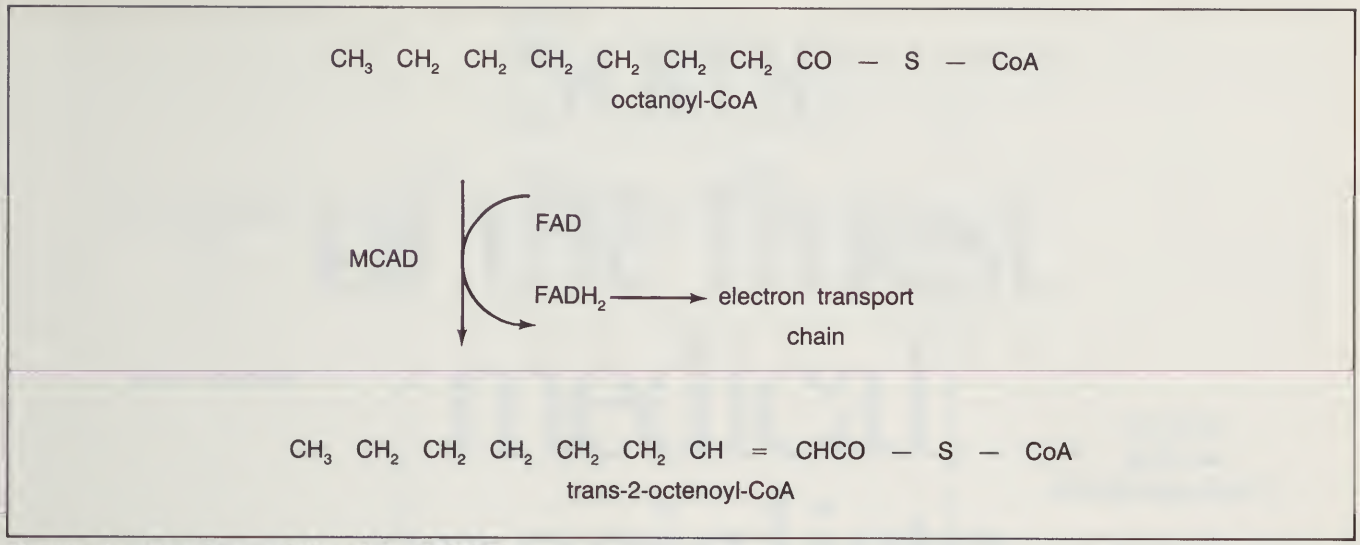


Figure 1. Reaction catalyzed by MCAD.

pionic acid is a bacterial metabolite formed in the gut by bacteria. Upon absorption, it is oxidized in man within the mitochondria by MCAD.[26] In MCADD, it cannot be oxidized and is metabolized to its glycine conjugate, 3-phenylpropionylglycine, that is excreted in urine. This metabolite may be unique to MCADD. Analysis of blood from MCADD patients revealed another potentially unique metabolite. Cis-4-decenoic acid is a 10 carbon monounsaturated fatty acid derived from the partial oxidation of linoleic acid. Its measurement may be of value in the diagnosis of MCADD when urine is not available.[27,28] This is of particular importance for the further investigation of SIDS, as urine frequently is not available.

Asymptomatic patients. In patients suspected of having MCADD but who are not symptomatic, the urinary profile is quite different. When normoglycemic, there is little flux through the β-oxidation pathway and, consequently, little accumulation of metabolites. However, the use of sensitive stable isotope dilution, mass spectrometric technology has made it possible to detect small elevations of hexanoyl-, 3-phenylpropionyl- and suberylglycine[23], and octanoylcarnitine[21] in urine from otherwise well MCADD patients. In plasma from asymptomatic patients there is elevation of cis-4-decenoic acid.[28] It is important to note that routine urinary or plasma organic acid screening is unlikely to detect asymptomatic MCADD and such investigations should be conducted in an appropriate laboratory.

Molecular genetics. MCADD is inherited as an autosomal recessive disorder with subsequent risk of 1 in 4 for siblings of a proved case. The disorder is found with high frequency in infants in northern Europe, in particular of British origin. The estimated frequency in a northern British population from metabolic studies was 1 in 12,000 infants[29] and from DNA studies was 1 in 13,400 infants.[30,31] To date, not a single Japanese, Hispanic, or African-American MCADD patient is known to us. Not surprisingly from the epidemiological data, a common genetic mutation prevailed in the at-risk white population. An adenine to guanine transition was identified at position 985 of the coding region in 90 percent of MCADD alleles. This results in a lysine to glutamate substitution in position 304 of the mature MCAD protein.[32-35] This led to the development of a simple strategy for the analysis of the common mutation based upon the introduction of a mutant allele-specific Nco 1 restriction enzyme cutting site and the use of obgonucleotide primers to both the normal allele (that does not contain the restriction site) and mutant allele (that does contain the restriction site). The use of polymerase chain reaction amplification of genomic DNA has made this technique applicable to small sample sizes.[32] Interestingly, position 304 of the mature MCAD protein does not appear to be close to either the active site of the FAD binding site and there is speculation over the relationship of the mutation to loss of enzyme activity.

Investigation of suspected MCADD. If blood and urine samples are collected during an acute crisis, there should be very little difficulty in obtaining a putative diagnosis of MCADD using the criteria listed in the Table. However, upon the restoration of normoglycemia when the patient is well, many of the abnormal parameters return to normal. Mass spectrometric analysis then is required in order to obtain a diagnosis.

The metabolic analysis can be followed up by confirmatory enzyme or DNA analysis on cultured skin fibroblasts of isolated white blood cells.

Investigation of infants who present with sudden death. Urine, the material of choice for metabolic analysis, frequently is not available when investigating a patient presenting as SIDS or any fatal life-threatening event, such

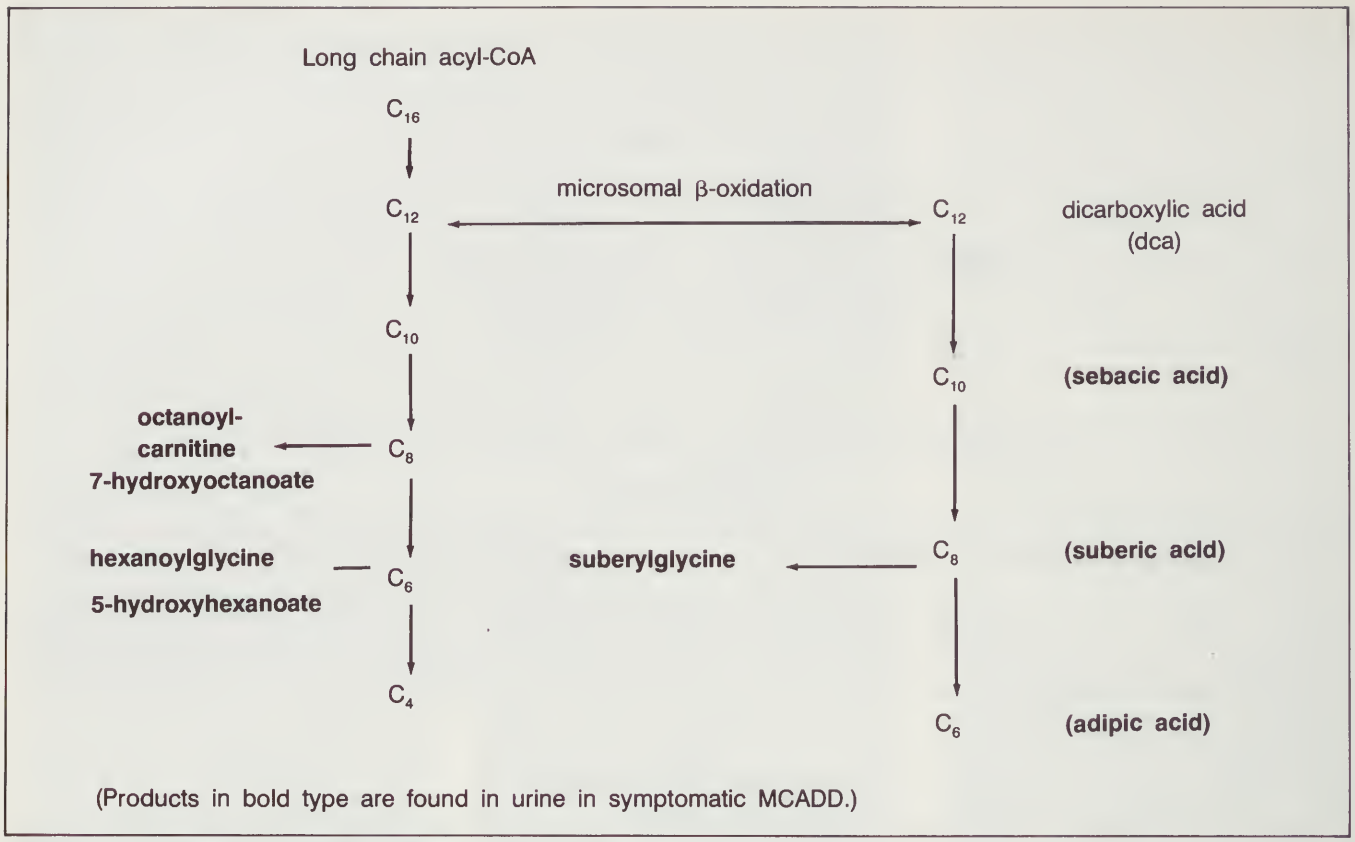


Figure 2. Alternate metabolic routes in MCADD.

as Reye's syndrome. Other body fluids have been utilized, including whole blood, that have been shown in a single case to contain cis-4-decenoic acid, acylglycines, and octanoylcarnitine.[36] Vitreous fluid has been analyzed from a single enzyme-confirmed patient with MCADD and shown to contain medium chain dicarboxylic acids and octanoic and 7-hydroxyoctanoic acids.[37] A protocol for the collection of body fluids and tissues for optimal investigation of SIDS infants had been published.[38] It has been shown that when only SIDS tissues that have been previously fixed in formalin were available and on which no metabolic or enzymatic studies could be performed, the analysis for the common DNA mutation can be successfully applied.[39] Thus, it is possible to develop a program to study all SIDS infants with regard to MCADD. However, in our opinion, MCADD should not be the only fatty acid oxidation defect tested for in SIDS samples. It is becoming increasingly clear to us that other fatty acid oxidation defects also are found in SIDS infants, possibly with the same overall frequency as MCADD[40,41] and that the SIDS investigative strategies should include other enzyme possibilities. The investigative strategies to uncover other disorders of fatty acid oxidation should be modeled upon our experiences with MCADD.

We have developed an excellent understanding of the normal molecular and biochemical aspects of MCAD, and of its role in the pathology of deficiency states. It is time to use this information to expand our knowledge into the other enzymes of fatty acid oxidation. ■

References available upon request.

Dr. Bennett is affiliated with the Metabolic Disease Center, Baylor University Medical Center, Texas. Dr. Hale is affiliated with the Division of Endocrine/Diabetes, The Children's Hospital of Philadelphia. Address reprint requests to Dr. Bennett, Baylor University Medical Center, 3500 Gaston Avenue, Dallas, TX 75246.

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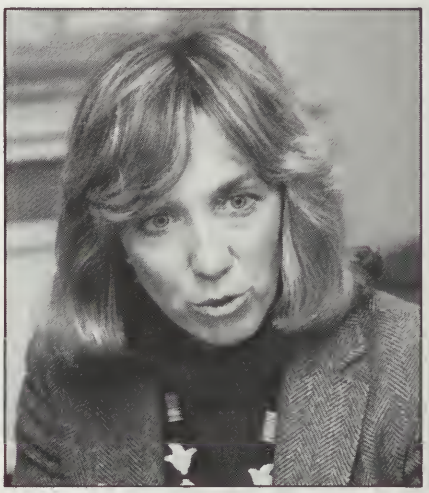
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Sudden infant death syndrome: Loss and bereavement

Donna A. Gaffney, RN, DNSc

Clinical perspectives of sudden infant death syndrome (SIDS) and family responses to loss and bereavement are addressed. The author discusses factors such as family stage, parental dyad issues, and the needs of young children, friends, and caregivers.



Donna A. Gaffney, RN, DNSc

The accidental or sudden death of a baby is one of life's most traumatic events. There is no way to emotionally prepare for such calamity; there is no anticipation because there is no forewarning. Unable to rationalize the death, survivors are left with a profound sense of confusion.[1] Sudden infant death syndrome (SIDS) initially denies the living any means of intellectually comprehending the death, a necessary step in the grieving process. Parents are left with a deep sense of guilt, arising from a seemingly endless number of sources.[2] Guilt is not restricted to the parental dyad alone; siblings, child caregivers, extended family, and friends all take partial responsibility for the death of the infant.

The birth of a new family member is an occasion for joy and a renewed sense of hope for the future. It is a time of unparalleled excitement and anticipation as each member of the family experiences a dizzying emotional high. Months of physical and emotional preparation bring the family to a new stage in their lives. SIDS not only thrusts the family into profound grief but takes them from one of the highest points of their emotional lives, abruptly and without warning. The family who at one time felt joy, now experiences loss; instead of looking forward to life with a new human being, they now mourn a person they barely knew. All of the hopes and dreams are shattered. Families are left with the difficult task of recovering from and integrating the loss of an infant.

Professionals and parents not only must understand the nature of the grieving process but how loss affects each family member, their relationships, and the family's development as a whole. Bereavement is a shared experience, each person's responses influencing the emotions and behaviors of other family members.

FAMILY LIFE CYCLE

Every family moves through different stages of development in the family life cycle, beginning with the formation of a couple and marriage to emancipation of adult children.[3] SIDS most often affects families who barely are out of the "couples" stage as they make the transition to the "families with young children" stage. There may be one or two very small children in the family or the SIDS baby may be the couple's first child.

Family members are novices—new parents struggling with their roles and the shock of their changing lifestyles. The couple is most likely still confronting their own relationship, cultural norms, and values from their partner's families of origin.

The young family has a brief history together. They will have limited experience with crisis, if any at all, and are unable to predict how significant others will respond. Support systems are not fully developed and adults may depend more on their families of origin rather than their partners. In many cases, SIDS is the first family crisis. The emotions and behaviors of family members may be traumatizing to each other and precipitate relationship issues or dysfunctional behavior. In an effort to help the family stabilize and begin developing growth-

promoting behaviors, professionals must appreciate the interaction within the constellation of family variables.

THE PARENTAL DYAD

Parents who experience the loss of their infant through SIDS not only are confronted with bereavement but with a crisis in their own relationship. Sharing their loss is even more painful as they look into the mirror of each other's pain. There is no avoiding the loss when they are with each other. Shared experiences of joy or happiness are avoided as they question commitment to each other and the reality of their infant's death. Even though parents look for support from each other, they are unable to get what they need because they are consumed by their own emotions. It is not unusual for a husband or wife to question the relationship, fantasizing about "starting over." Such thoughts provide an escape from the pain of the present and a denial of positive relationships of the past. Thoughts of dissolving the marital relationship can grow especially if the couple has had difficulty in the past.

This is a time for marital counseling and family support. Death in a family does not cause divorce, it is the precipitant of prior relationship issues.

Adult family members have their own personal bereavement histories.[4] They bring this history and previous experience with them to their marriage and the new crisis. Old coping behaviors learned during prior traumatic events will be used for the present crisis as earlier losses are regrieved. If previously learned behaviors were growth promoting, then growth will continue; however, if the earlier experience was problematic, then coping with the current situation also will be a problem. Couples struggle to accept and respect their individual grieving styles. If the marital dyad has become dysfunctional, the couple must seek assistance for their relationship as well as for their shared bereavement.

SIBLINGS

The deepest pain for parents is the simultaneous expression of their own grief and witnessing the grief of their children. There is a continuous attempt by well meaning adults to spare children the pain of loss. Sheltering or protecting children from mourning translates into isolation.[5] The younger the children, the greater the adult's need to remove them from the events following the death of a family member. Adult family members need support and assistance from friends and family as they share their own grief with that of their children.

The family confronted with SIDS often has young children who have a limited understanding of pregnancy, birth, and death. Their ability to comprehend SIDS is complicated. Children under the age of five years tend to use magical thinking to explain the world. Their concept of death is equally magical and contributes to the notion that death is reversible. The permanent separation from one who has died is incomprehensible as evidenced by the frequent questions regarding the return of the dead baby. These toddlers or preschoolers also have the challenge of surviving the trauma of displacement within the family hierarchy. Without warning, the new life that has created so much chaos in their previously secure existence is gone, leaving in its place a more painful experience. Children not only lose a sibling but they lose the emotional bond with their parents as well. It is important to consider the special needs of children during this time of family mourning.

Children, at any age, grieve differently than adults. They may have briefer periods of sadness or express their feelings in ways that cause them to alienate others. Sometimes, it appears they go on with the business of their lives unaffected by the loss in their family. Younger children have difficulty articulating their feelings, choosing to act out, or to ask an endless number of questions instead.

The real and imagined separation between parents and children is of critical importance to the young child's response to loss. Removing children from the home, allegedly sparing them the pain of grieving, will intensify confusion and anger at a later time. Children who witness their parents' emotional responses to loss will not be scarred for life. However, fantasies of what they think is happening (in their absence) remain with children for a very long time and often is far worse than reality.

Sibling rivalry begins to surface prior to a birth in the family, intensifying as the new infant requires more attention from the parents. Confusion and resentment motivate aggressive behavior in young children requiring parents to delicately balance support and discipline. Sibling rivalry does influence the young child's response to SIDS. Without warning, magical thoughts and wishes of removing the infant from the family become a reality. The egocentric child assumes he is responsible for the family tragedy. Unable to verbalize his fears, the child holds back and retreats into isolation. It is important for perceptive and loving adults to reassure the small child that the death is not his fault. Egocentricity is a developmentally bound characteristic in young children; consistent and simple reassurances are necessary until the child is able to understand the death of his baby sibling.

Children pass through a series of cognitive developmental stages that influence the way they perceive the world.[6] Toddlers and preschoolers have a limited knowledge of death and almost no awareness of internal body parts and functioning. Attempting to explain SIDS in a scientific manner will serve no purpose and only further confuse the child.

Children respond to comfort, honesty, and caring words from people they know and love. Parents are the best people to support their children. Bereavement is not a time for substitute parenting. It is helpful for families to have a third or fourth adult to help with daily tasks while the parents provide the emotional support for the children.

RECOVERY AND COHESION

Families have a monumental task as they grieve the loss of an infant. Well-meaning extended family and friends often supply words that fall short of the comfort and support they are supposed to provide. Society has overlooked the loss of an infant. Families must grieve the loss of these individuals just as they mourn the loss of those known to them for many years. Children must be included in funeral or memorial services. It is important for the entire family to be a part of the experience. Adults must be cautious never to minimize the impact any loss has on children; losing a sibling to SIDS is significant and never forgotten. Children need their parents help to comprehend and integrate what has happened. Explanations of the events surrounding the baby's death should be given in direct and simple terms. Families who choose religious explanations for their children need to avoid referring to the "specialness" of the infant as a reason for why he is dead (and gone to live in heaven). Young children will interpret this explanation to mean that they are not special, reinforcing the fear of their own responsibility for the death.

Children will have memories of the baby, the appearance, the behavior, and interaction with the infant. Preserve those thoughts and feelings in a concrete way; memory books can be an ongoing tribute to the life of the smallest family member.

Future pregnancies in the family may precipitate more questions and fears from children. Parents need to be aware that this is an understandable response from every family member, young and old. Reassurance should be honest, informing children that most babies are born healthy and stay healthy. Allow children to talk about their feelings, encourage parents to express theirs as well. Adults should not pressure children to talk; sometimes thoughts are more easily expressed at a later time. Grief can be a lonely experience, but if families are encouraged to share the process with each other, they will grow through their crisis. ■

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Dr. Gaffney is affiliated with Columbia University, School of Nursing, New York. Address reprint requests to Dr. Gaffney, 57 Winchip Road, Summit, NJ 07901.

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Sudden infant death syndrome and subsequent siblings

Mary Terese Carbone, MD

The author discusses the risk of sudden infant death syndrome (SIDS) in subsequent siblings, summarizes the results of cardiopulmonary evaluation in these infants, and highlights current therapeutic strategies of medical management for infants.



Mary T. Carbone, MD

Laterus reported a sudden unexpected infant death (SIDS) in siblings in 1614.[1] More than three and one-half centuries later, the pathophysiology leading to repeated deaths in some families remains unknown. Similarly, the role played by inheritance and environment continues to be debated. Controversy prevails regarding the risk of SIDS among siblings of SIDS victims and, consequently, evaluation and management of these infants are quite challenging.

INCIDENCE

SIDS risk in subsequent siblings is controversial.[2] The first estimate of the recurrence rate for SIDS was by Adelson and Kinney in 1956; 2 siblings were affected among 126 SIDS cases, resulting in a rate of 16/1,000 siblings, which was 5 to 8 times greater than that in the general population.[3] A study from northern Ireland in 1971 found the relative risk of SIDS siblings to be 5.6, but subsequent reports found the relative risk to be approximately 10.[4-6]

Later studies from Norway and Washington State indicated the incidence was 3.7 times greater than in control infants.[7,8] The authors concluded that earlier estimates resulted from methodological flaws, i.e. parental reporting of SIDS among prior born siblings. These subsequent reports were based instead on data using linked birth and death records. However, a recent study using linked birth and death records from Oregon found the relative risk to be 6.[9] Thus, it appears that the relative risk following a single SIDS death is between 3.7 and 10 for subsequent SIDS siblings. Data are summarized in the Table.

With regard to subsequent siblings of 2 or more SIDS infants, the reported incidence is quite high, 180/1,000 infants.[10] Thus, there is a pattern of recurrence within the family that adds to the tragedy of this syndrome, and the role of genetic and environmental factors has been questioned. Non-Mendelian factors or strong environmental influences during gestation or postnatal life may be involved. Since numerous epidemiologic risk factors have been identified, including race, birth order, birthweight, and maternal characteristics such as age, marital status, socioeconomic status, and smoking, those risk factors that will remain with the family after the initial SIDS loss must be taken into account.

EVALUATION

Infants die during sleep in 90 percent of the cases of SIDS. Studies, thus, have compared cardiopulmonary variables during sleep in infants at risk for SIDS. Higher respiratory rates and a greater degree of variability in breathing have been noted in SIDS siblings.[11,12] A higher degree of periodic breathing also has been described in subsequent siblings in home pneumocardiogram studies[13] and in response to hypoxic challenges in the laboratory.[14] Such data lend support to the hypothesis that an inappropriate response to hypoxia may be a major contributing factor in SIDS.

Evidence indicates that risk infants, in fact, may be initially challenged in utero. A study ex-

amining fetal heart rate (FHR) variables during maternal sleep in subsequent SIDS siblings found acceleration-deceleration patterns and increased overall FHR variability in the siblings consistent with mild chronic hypoxia.[15]

One must emphasize that while certain cardiorespiratory markers have been found in some SIDS siblings, the absence of these markers in other infants who eventually died of SIDS highlights the inability to predict which infants will succumb to SIDS. The limitations imposed by cardiorespiratory control analyses must be taken into account when means of intervention are sought.

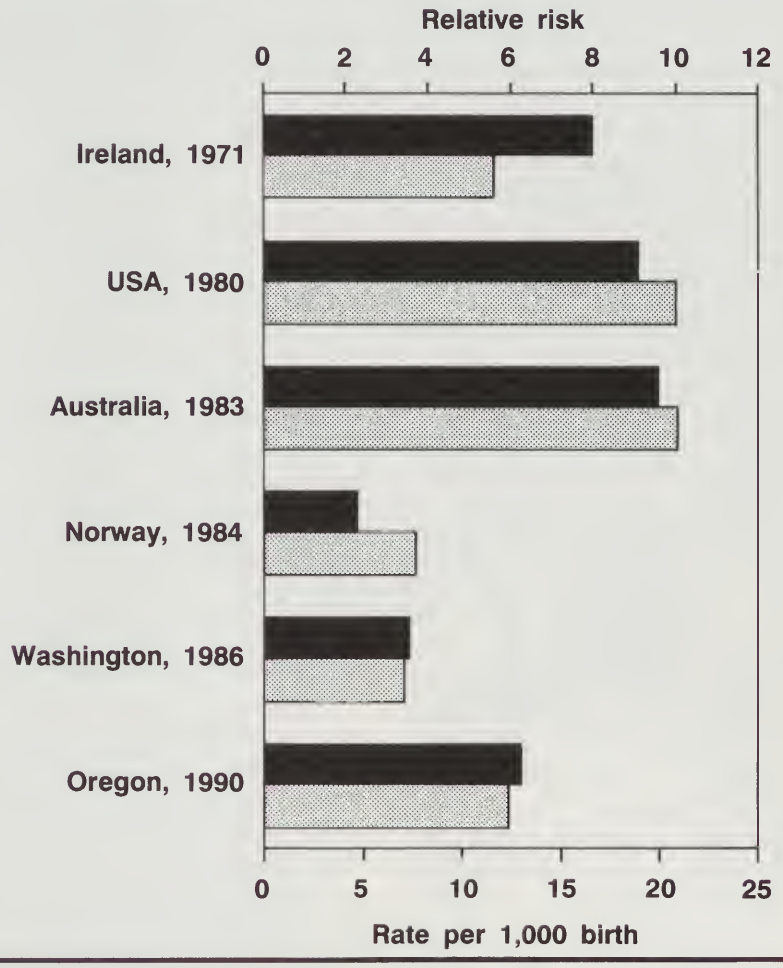
INTERVENTION

The use of electronic home monitoring has been advocated for subsequent siblings as an available alternative for preventing life-threatening events and assisting families in coping with stress.

The concept of monitoring respiration is not new. It was first described in the 1700s in New England graveyards.[16] A string, tied around the chest of the buried corpse, was brought through a tube to the surface and attached to a bell. The ringing of the bells was "monitored" by the graveyard sexton who, if indicated, would exhume the body to ensure the person's survival.

As the 1970s and 1980s unfolded, the use of electronic monitoring in the home environment has provided surveillance for certain groups of infants at high risk for sudden death. The basic reason for considering electronic surveillance of potential value in the prevention of SIDS is based on the fact that, regardless of the cause, the terminal event is cardiorespiratory failure. Thus, early resuscitation may be successful. Data support prolonged apnea and/or bradycardia as part of the pathophysiology of SIDS. The clinical impression that these life-threatening physiologic disturbances may be aborted if a monitoring system permits early detection by personnel well-trained in resuscitation is the basis for this intervention.

Table. *Rates and relative risk of death in siblings of SIDS victims.*



There are many different monitoring devices available, including alarms for apnea, bradycardia, and both. Transthoracic electrical impedance monitors that detect electrocardiogram (ECG) and chest wall movement have the widest availability in the United States. Although an impedance transducer will not be able to identify obstructive apnea (respiratory movements not accompanied by airflow), the bradycardia that typically accompanies this will be identified by the cardiac rate detector.

Current technology permits maintenance of a continuously updating memory of cardiac and respiratory signals by the addition of an event recording system to the home monitor. Documented monitoring, by providing a hard copy analysis of all monitor alarms, can help attenuate parental concerns related to false alarms, i.e. alarms of nonpathophysiologic significance.[19] The use of pulse oximeters in the home provides the opportunity to monitor blood hemoglobin oxygen saturation as a means of detecting hypoxemia in association with apnea and bradycardia. The addition of an oxygen saturation channel to the cardiorespiratory recording may enhance our understanding of the pathophysiology of SIDS and can provide a powerful means of diagnosis and intervention.

The cost of home monitoring is a psychological, social, and financial one. Both retrospective and prospective studies of the impact of home monitoring on the family highlight the need for a support system encompassing medical,

technical, psychosocial, and community services. This clearly goes beyond caretaker training in monitor use and cardiopulmonary resuscitation. When an educational and psychosocial support system are provided, home monitoring has resulted in a satisfying experience.[17,18]

While home monitoring may provide support for parents of a subsequent SIDS sibling, some infants have died while being monitored,[20] and so feasible alternatives have been sought. Epidemiological evidence that some infants dying of SIDS have growth retardation[21] led British investigators to conduct a randomized control trial comparing weighing scales with apnea monitors for SIDS siblings.[22] While both systems were acceptable and gave parents confidence, general support provided by weekly home health visitors was described by parents as invaluable. No conclusions were reached regarding the role of either home monitoring or weighing scales in the prevention of SIDS.

SUMMARY

Studies indicate that at least 98 percent of all subsequent SIDS siblings will have a normal outcome. While the data regarding a single SIDS occurrence can be viewed as encouraging, 2 percent mortality is not trivial. Parents of SIDS siblings are in need of appropriate counseling and support. In the unfortunate case of subsequent sibling SIDS deaths, the mortality rate may be as high as 18 percent.

Regretably, all attempts at prospective identification of infants destined to die of SIDS have proved futile. The development of a prospective screening test has been hindered by insufficient understanding of the specific cause or causes of SIDS. Attention, thus, has been directed at the development of effective home intervention.

Cardiorespiratory monitoring has been identified as one means of home intervention, and a comprehensive support program has resulted in the successful home monitoring of many infants at high risk for SIDS. Studies aimed at making prospective identification a clinical reality continue. Accordingly, we must persist in our efforts to provide support to parents who have experienced one of life's worst tragedies. ■

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Dr. Carbone is medical director, Infant Apnea Program, St. Peter's Medical Center, and assistant professor of clinical pediatrics, UMDNJ-Robert Wood Johnson Medical School. Address reprint requests to Dr. Carbone, St. Peter's Medical Center, 254 Easton Avenue, New Brunswick, NJ 08903.

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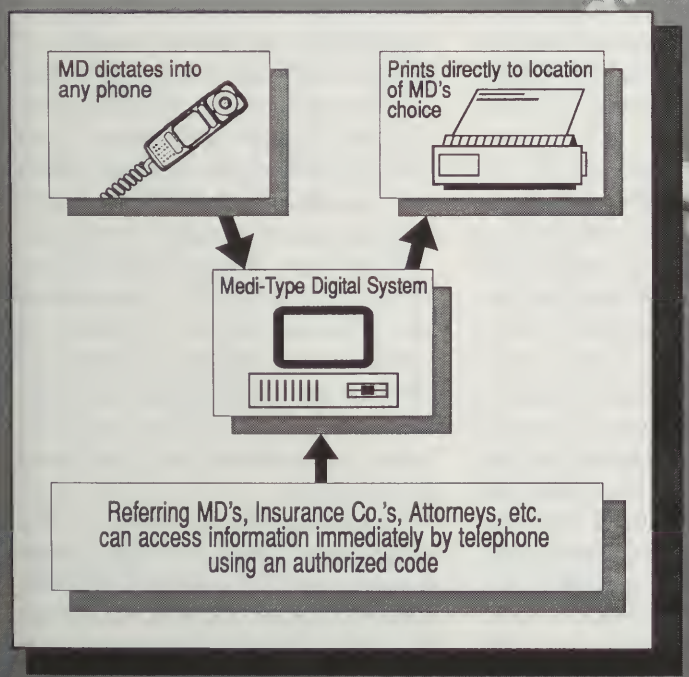
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Neurodevelopmental outcome in infants with apnea

Anne H. Koons, MD

The neurodevelopmental outcome of term infants with acute life-threatening events (ALTE) and preterm infants with persistent apnea of prematurity were compared to matched control populations. No differences in developmental outcomes were seen between the study and control populations.



Anne H. Koons, MD

When compared to the extensive body of information about neonatal control of respiration, there is little information concerning the effects of apnea on later development. Preterm newborns frequently experience apnea without any other problems; however, apnea may be associated with serious illness such as intraventricular hemorrhage (IVH), sepsis, or seizures. Genetic variability, developmental maturity, sleep state, and feeding activity may influence respiratory control, complicating etiological considerations. A unifying concept explaining all apnea has not emerged, and considerable effort continues to understand this common and troublesome symptom. Because of the multiplicity of events associated with apnea, a single consensus has not emerged concerning the long-term implications of the problem. Yet, current data suggest that both the causes and effects of apnea have important implications for the central nervous system (CNS). This report discusses some of the consequences of apnea on long-term brain function.

Considerable attention has focused on possible CNS dysfunction in infants suffering from prolonged apnea. Neurologic abnormalities are implied from evidence of CNS dyscoordination of respiratory rhythmicity.[1-5] Hypoxia and hypoventilation have been hypothesized as primary events leading to apnea,[6] and abnormalities of the cerebral circulation have been demonstrated during apneic events. A consistent decrease in cerebral blood flow velocity during episodes of severe bradycardia suggests a possible mechanism producing brain injury through perturbation in circulatory control.[7]

The presence of CNS abnormality in infants with disorders of respiratory control is supported by the pathologic studies of infants with sudden infant death syndrome (SIDS) that revealed nonspecific abnormalities in the microstructure of the brain compatible with hypoxic injury.[8,9] Naeye's findings of autopsy lesions that are consistent with previous chronic hypoxia also support the association between SIDS and hypoxia.[10-12]

The clinical studies of CNS function in term infants with apnea and acute life-threatening events (ALTE) have resulted in conflicting findings. There appears to be delayed auditory evoked responses,[13] delays in auditory arousal,[14] and abnormalities in the neurologic examinations at three months of age.[15] However, using the electroencephalogram, Clancy and Spitzer evaluated cortical function in infants at risk for SIDS and concluded that CNS cortical immaturity does not play a significant role in the pathogenesis of SIDS.[16] Kahn, in a controlled study to assess the outcome of infants with ALTE, showed no differences in physical, growth, and neurologic evaluations. The same conclusions were confirmed by Levitt.[18]

There are several small studies examining outcomes of premature infants with apnea.[19-22] Jones found 4 of 20 premature infants had handicapping conditions: 1 infant was blind, 1 infant was

deaf, and 2 infants had cerebral palsy and retardation.[21] In reporting on the outcome of 28 premature infants with various types of apnea, Butcher-Peuch concluded that infants with obstructive apnea greater than 20 seconds' duration had evidence of neurologic abnormality.[22] When compared to a group of 10 infants with central or mixed apnea, the obstructive apnea group had a higher incidence of IVH, hydrocephalus, and mechanical ventilation, confounding the direct relationship between apnea and handicap.

Because of our concern for developmental sequelae in infants with apnea, a longitudinal multidisciplinary neurodevelopmental followup is available at St. Peter's Medical Center. The program is staffed by a team of developmental specialists: a pediatrician, psychologist, and neurodevelopmentally trained physical and speech therapists. The evaluators are unaware of the infant's apnea status or perinatal history. The assessments include a pediatric examination, neurologic examination, and neurodevelopmental physical therapy examination. Hearing is tested by behavioral audiometry in infancy and by brain stem-evoked responses in the neonatal period. Language testing includes the Bzoch-League Receptive-Expressive Emergent Language (REEL) Scale in the first year and the Sequenced Inventory of Communication Disorders (SICD) in the second year of life. An oromotor evaluation assessing the peripheral speech mechanism, oral reflexes, feeding assessment, breathing, vocalization, and articulation also is performed. Pediatric ophthalmologic and retinal examinations are completed routinely for infants who were premature and, if indicated, by the vision assessment of the neurologic examination. Developmental testing is performed by a developmental psychologist employing the Bayley Scales of Infant Development for infants less than 30 months of age. The Bayley Mental Developmental Index (MDI) and Psychomotor Developmental Index (PDI) greater than 85 are considered as normal with scores of 70 to 85 indicating mild delays and scores less than 70 indicating delay. Language delays are defined as receptive or expressive language performance below two months of expected norms. Positive hearing responses to screening between 500 Hz and 4,000 Hz and responses to sounds less than 25 decibels are considered as normal. Cerebral palsy is defined by defects of motor function including spasticity, severe hypotonia, or hemiparesis. All infants suspected of having cerebral palsy are further evaluated by a pediatric neurologist to confirm the diagnosis.

Both term and preterm infants with apnea have been included in the followup program. In one study, a group of 27 term infants with ALTE was followed throughout infancy and compared to a comparable control group of 21 term infants. Between one to two years of age, the Bayley scores of 26/27 of the term ALTE group were in the normal range (MDI 115+/-17, PDI 108+/-15) compared to 20/21 control infants (MDI 118+/-16, PDI 107+/-18). One child in each group had Bayley scores in the mildly delayed range. In early outcome, the ALTE did not appear to impact negatively on development.

The studies on outcome of our preterm infants with apnea also are similar to the outcomes of premature infants without apnea. When matching a group of 60 premature infants who had apnea at the time of discharge from the nursery and requiring home monitoring with a group of infants of comparable gestation, birth weight, and degree of neonatal illness (IVH, mechanical ventilation, and chronic lung disease) but without persistent apnea or monitoring, there were no differences in outcomes between the groups. However, the entire preterm population, those infants with and without apnea, had an incidence of developmental abnormality as defined by Bayley scores less than 85, or abnormal neurologic examinations, or visual or hearing impairment of approximately 16 percent. These outcome studies are confounded by the multiplicity of medical problems experienced by premature infants and that coexist with apnea.

There are reasons why it is interesting to speculate that there is not a clear cause-and-effect relationship between the presence of ALTE or persistent apnea with abnormal developmental outcomes. Although there are numerous gaps in our knowledge of the fetal and neonatal respiratory control, almost all of the available data disassociates the development of CNS respiratory control from the development of higher cortical function. The pathway for the control of breathing has as its afferent limb the peripheral and medullary chemoreceptors and protective reflexes. Although cortical input is present, it is not necessary for breathing and it primarily is manifested through the sleep state. Infants with profound cortical defects as in congenital anomalies of CNS often do not have neonatal apnea. The area of the brain that controls respiration is in the brain stem.[23] The efferent limb of the respiratory pathway includes the respiratory muscle system including upper airway as well as thoracic and abdominal muscles and the peripheral nervous system and spinal cord. The independent development of the respiratory pathway and cortical function is likely.

Another reason why we may not be seeing more developmental problems with apnea is that current standards of care have fostered aggressive pharmacological intervention, and the increasing use of home monitoring may be preventing the type of episode that could irreversibly

impair infants with apnea.

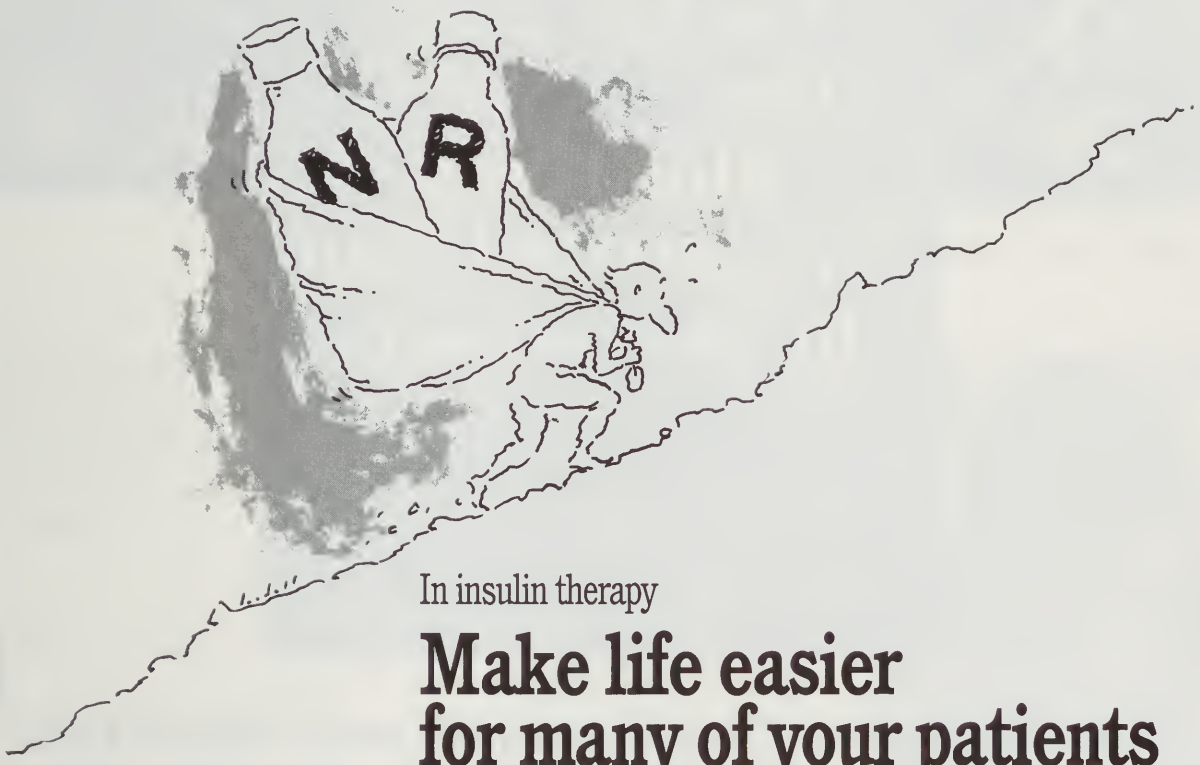
It is encouraging that the neurodevelopmental outcome of our patients with apnea is comparable to age-related controls. However, we acknowledge the potential harm that can result from prolonged and possibly persistent apnea and bradycardia but believe that perturbation will be minimized by our current trends of aggressive treatment.

Obviously, more specific data are necessary, particularly in relating the characteristics of apnea, i.e. central versus obstructive versus mixed, or apnea with and without severe bradycardia with long-term consequences. As we identify the causes of apnea more clearly, it will be important to study each different subset of patients separately to determine if certain relationships, e.g. obstructive apnea, are more or less benign in relationship to subsequent development. ■

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Dr. Koons is director of High-Risk Followup, St. Peter's Medical Center and a member of the Division of Neonatology and associate professor of clinical pediatrics, UMDNJ-Robert Wood Johnson. Address reprint requests to Dr. Koons, St. Peter's Medical Center, 254 Easton Avenue, New Brunswick, NJ 08903.



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NJ SIDS Resource Center: Program for bereaved families

Barbara M. Ostfeld, PhD
Pamela Buckalew, RN, MSN, CS

The New Jersey Sudden Infant Death Syndrome Resource Center counsels approximately 120 bereaved families each year, conducts medical and community education programs, and manages the sudden infant death syndrome database for New Jersey.



Barbara M. Ostfeld, PhD



Pamela Buckalew, RN, MSN, CS

The impact of sudden infant death syndrome (SIDS) is measured primarily in statistics of mortality. However, if the definition of victim is extended to the surviving family, then the impact of SIDS includes extensive and enduring morbidity. SIDS has been described as the most severe loss a parent can experience.[1] Parental grief in response to the sudden death of a seemingly healthy infant has been characterized as boundless,[2] devastating,[3] and almost unbearable.[4] Although most parents ultimately cope and function adaptively, the emotional sequelae of the loss present a continual challenge throughout their lifetime.[2]

Studies have found that accurate information[5] and early access to supportive counseling are therapeutic and can temper some of the maladaptive responses to the loss.[6] In 1988, the New Jersey State Department of Health (NJDOH) responded to these findings and to the recommendations of bereaved parents. With a NJDOH grant, St. Peter's Medical Center established the New Jersey Sudden Infant Death Syndrome Resource Center (NJSRC) to serve the needs of New Jersey families facing this crisis. Approximately 500 families have received services without cost. NJSRC's mandate also includes the ongoing education of physicians and first responders and the management and analysis of the database that yield the epidemiological profile and pertinent research questions.

CRISIS INTERVENTION

In addition to confronting issues shared by grieving parents, SIDS parents encounter unique sources of distress. Of greatest psychological impact is the absence of a known cause. Struggling to understand what has happened, these parents experience an intensified sense of guilt,[6] assuming incorrectly that the responsibility was theirs by deed or by inaction. Feelings of guilt can be exacerbated by the presence of illness prior to the infant's death.[7] Common misconceptions that SIDS is due to suffocation or child abuse also have an impact upon parental distress. Finally, surviving children respond with anxiety to the concept of an unanticipated crisis. Their vulnerability contributes to the grief of their parents.

SIDS parents benefit from timely counseling and from information to correct misconceptions about the syndrome. These services enhance their ability to cope with emotions and assist surviving children. In 1991, 120 New Jersey families were referred to NJSRC for such services. The staff makes every effort to respond to families within 24 hours after NJSRC has been

notified of the death by the medical examiner's office. Packets of information about SIDS, the grief process, the services of NJSRC, and parent support groups are sent out immediately. A sequence of telephone contacts and written communications results in an average of eight contacts per family, annually. The pattern of calls is individualized in response to need. Minimally, the calls occur one week, two weeks, one month, and two months after the death and average one hour in length. Holiday mailings and birthday memorial cards are sent. Families with ongoing counseling requirements are referred to local counselors. This group is comprised of psychologists, nurse psychotherapists, social workers, or psychiatrists in private practice or affiliated with a community mental health center. Prior to receiving a referral, the counselor advises NJSRC about training in bereavement, ability to serve adults, families, or children, and the availability of a sliding fee scale. Twenty-five families of the 120 families served in 1991 (21 percent) received adjunct counseling. Thirteen families were referred by NJSRC, and 12 families obtained services through other networks.

Six months after the death, families are surveyed to evaluate changes in grief patterns and needs. A pilot study based on an early form of this survey revealed that although the acute reactions had abated, symptoms of grief remained measurable. Many families had experienced further changes in their lives that they attributed to the loss. The sequelae of events following the death underscore the importance of continued contact between the family and support systems such as NJSRC. Over 50 percent of the families already had moved or were planning their relocation. Nearly 40 percent were pregnant or attempting to conceive. While 90 percent of the married couples maintained or improved the quality of their relationship, only 28 percent of single parents did.[8] The stability and the enhancement of the marital relationship are consistent with other findings[3,6] and dispute conclusions drawn in earlier studies that such a loss is predictive of marital discord. Rather, the quality of the marital relationship prior to the death must be considered as the important variable in predicting which marriages will be more vulnerable to the effects of grief.[6] The absence of a stable significant relationship for single parents is of particular concern to NJSRC; 50 percent of its parents fall into this category. Anonymously, families also assess the value of various services. They report favorably about the impact of NJSRC, parent support groups, family, and friends. Parents expressed their appreciation for pediatricians who have provided support through timely and frequent contact. The lack of communication from the medical provider resulted in the intention to replace the physician.[8]

NJSRC uses visiting nurse agencies (VNAs) to extend services through home visits. These nurses have been chosen for their interest and compassion and are informed about SIDS counseling techniques and SIDS research. This education program includes discussions about the grieving process focusing on individual differences due to gender, culture, and personality. Nurses learn that grieving parents fear that their feelings and behavior are abnormal and are symptoms of mental illness.[9] Reassuringly, however, studies of parental responses indicate that the reactions that concern many parents, such as hearing the cry of the deceased baby,[3] turn out to be transient experiences shared by many other families. A crisis involving one's children does not in itself predispose the family or the individual to become dysfunctional.[10] Rather, as discussed in the training sessions, characteristics of family functioning and individual coping styles that preceded the event must be considered. Nurses must be recertified in this program every two years. In 1991, 44 percent of the families contacted agreed to receive these visits, which averaged two per family. In appreciation of the invaluable service of VNA, a representative of the profession is honored annually at the SIDS conference.

To provide 24-hour emergency service for bereaved parents, NJSRC established a hotline monitored by nurse clinicians with expertise in counseling. Of the 287 telephone calls received this year, 99 calls were families calling to initiate a counseling session, 91 calls were from medical examiners, physicians, or first responders with referrals, and 97 calls were for information. During the initial contact, the family is asked to give permission to have a parent from the SIDS Alliance, New Jersey Affiliate, a peer support group, contact them with additional information and support. If families are uncertain about receiving such a call, they are encouraged to contact the parent representative. VNA reinforces this resource during the home visit.

Children too young to comprehend the event react to changes in their daily routines and in their parents' behavior.[11] Families sometimes avoid discussing the child who died. Parents may resist displaying their emotions, hoping that this silence will protect the surviving children from grieving. However, it is clear from interviews with surviving siblings that silence does not protect but merely isolates. In 1991, there were 129 surviving siblings ranging in age from one year to young adult. The goals of NJSRC sibling support groups and workshops are to assist parents and children to cope and to provide siblings a setting for the expression of their issues. In contrast to their worst fears, parents learn that the mental health of their children is not

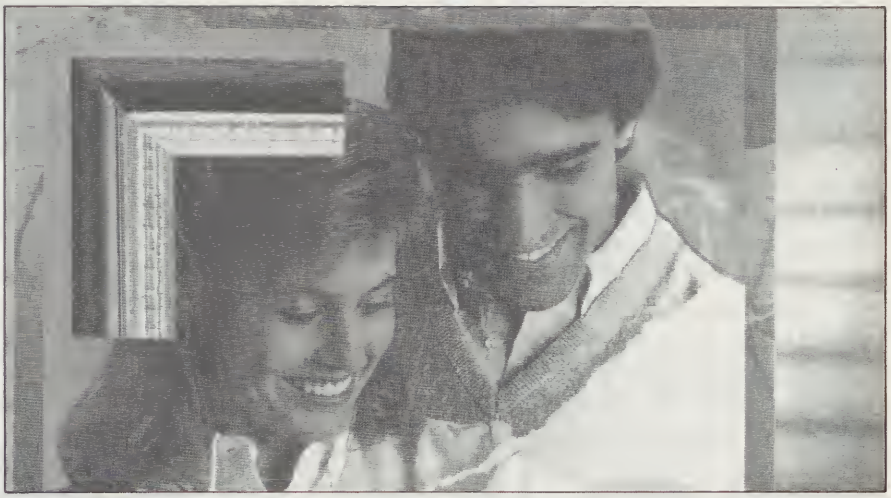
automatically and irreversibly damaged by grief. Many disturbing findings about the long-term impact of death on siblings were based on case reports or retrospective studies of adult survivors. The results of these studies often were skewed in the direction of adverse outcome due to inclusion bias or emphasis on negative effects. Compensating events and interventions were not considered.[12] Speaking of the impact of a chronic medical illness upon a sibling, Tritt and Esses pointed out that studies "would benefit from a shift from preoccupation with universal negative effects to a less biased focus that includes siblings who cope well."[13] Available data suggest that there is a variance in outcome and that supportive intervention by parents and/or others can contribute to a more positive consequence.[14]

Finally, NJSRC supports the attending physician in his relationship with the family. A physician experiences strong emotional reactions in response to the death of a patient that may interfere with communications to the parents.[1] Through workshops, printed materials, and telephone contacts, NJSRC enhances the physician's ability to meet the emotional and informational needs of stricken families.

To prepare future physicians to cope with death and dying in a pediatric population, an annual nine-hour elective seminar is conducted for second-year medical students at Robert Wood Johnson Medical School. Lectures and discussions are supplemented by informal discussions with physicians and bereaved parents.

EDUCATION

NJSRC holds an annual conference providing the audience with a medical keynote address on promising directions in research related to the etiology and prevention of SIDS and a psychosocial keynote address on interventions with bereaved families. Presentations also focus



upon the profile of SIDS in New Jersey, with an update on its epidemiology and on programs serving populations at risk for SIDS.

In addition to this annual series, NJSRC distributes a biannual newsletter that updates physicians on relevant scientific research and new developments. This communication is supplemented by workshops and grand rounds held throughout the state. In 1991, over 27 community education programs served 531 registrants.

Community education also is provided through the dissemination of SIDS information packets, individualized to meet the needs of the recipient. This year, 868 packets were sent to parents, physicians, VNAs, consumers, nurses, first responders, social workers, funeral homes, conference participants, and DYFS workers.

NJSRC works closely with the speakers bureau of the New Jersey Affiliate of the SIDS Alliance, the parent support network, and participates in the design and presentation of its speakers training workshops. Parents who participate in this training sometimes join NJSRC staff in addressing community groups.

DATA MANAGEMENT

By state mandate, NJSRC obtains data on each SIDS death from information provided by the medical examiner and parents. This information is supplemented with a VNA information sheet addressing risk factors. All data are maintained in strictest confidence and are reported as an aggregate. If the VNA is unable to make a home visit, a NJSRC staff member contacts the family to review the questionnaire. The information obtained on each case contributes to the New Jersey database that then provides us with an annual profile of SIDS in New Jersey.

NJSRC cooperates with the New Jersey state medical examiner to develop uniform recordkeeping and transmission of information. Rapid exchange of information enables the parents to be referred promptly when the need for service is most acute. Timely processing of autopsy findings and swift confirmation of the diagnosis of SIDS facilitates the grieving process.

NEW CHALLENGES

NJSRC staff reviews all research pertinent to SIDS. When promising new directions emerge, NJSRC, in association with the Division of Neonatology, explores ways to promote further study or to disseminate information to the state's physicians. In 1991, as a result of this process, St. Peter's Medical Center received a grant from the New Jersey State Department of Human Services, Office for Prevention of Mental Retardation and Developmental Disabilities to create a statewide medical education project on

medium chain acyl-coenzyme A dehydrogenase deficiency (MCADD). This treatable genetic disorder of fatty acid metabolism has been found to account for a small proportion of deaths originally attributed to SIDS.[15] Through grand rounds, dissemination of printed material, and publication of review articles, the project presents information concerning the biochemistry of this disorder, its epidemiology, the effects upon infants and children, newly available diagnostic techniques, and treatment strategies.

CONCLUSION

Since 1988, NJSRC has served the needs of 500 families referred following a sudden infant death. Bereavement counseling and accurate information about SIDS contribute to the ability of these families to cope with the acute and long-term effects of this devastating loss. The community and medical education programs offered by NJSRC raise public and professional awareness of this disorder's impact upon families and promote research and service development. The database maintained by NJSRC enhances the physician's knowledge about the epidemiology of and risk factors associated with SIDS in New Jersey. ■

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Dr. Ostfeld is associate director, New Jersey SIDS Resource Center, director of pediatric psychology, St. Peter's Medical Center, and clinical associate professor of pediatrics and psychiatry, Robert Wood Johnson Medical School. Ms. Buckalew is SIDS outreach nurse, New Jersey SIDS Resource Center. Address reprint requests to Dr. Ostfeld, St. Peter's Medical Center, 254 Easton Ave, New Brunswick, NJ 08903.

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Sudden infant death syndrome: An overview

Michael A. Graff, MD
David G. Ramos, MD

The diagnosis of sudden infant death syndrome (SIDS) depends on a thorough and complete autopsy. Many of the infants who die of SIDS have common findings. There are certain steps to be taken for prevention and diagnosis of SIDS. Further investigation of this syndrome still is necessary.



Michael A. Graff, MD



David G. Ramos, MD

Sudden infant death syndrome (SIDS) or crib death is not a new disease. Over the years, SIDS has been attributed to a wide variety of causes: infanticide, overlaying, suffocation secondary to a large thymus, and milk sensitivity. While there does not appear to be a single cause of SIDS, the literature suggests several pathophysiologic events that may contribute to the disease.

DEFINITION

A definition of SIDS is used when the "sudden death of an infant under one year of age remains unexplained after a thorough case investigation, including performance of a complete autopsy, examination of the death scene, and review of the clinical history."[1-3]

EPIDEMIOLOGY

The incidence of SIDS varies throughout the world. The highest incidence of SIDS occurs in New Zealand (8/1,000) and the lowest incidence of SIDS occurs in Hong Kong (0.4/1,000). In the United States, SIDS occurs in approximately 2 out of every 1,000 live births. Within the United States, there is a wide variation in the incidence among ethnic groups: American Indians appear to have the highest incidence (5.3/1,000) and Asians living in the United States have the lowest incidence (0.5/1,000). It is interesting to note that the incidence of SIDS in second and third generation Asians approaches that of the general population.[4]

A number of epidemiologic studies have been designed to reveal common factors that are characteristic of SIDS.[5-6] Naeye found that SIDS was more common in small infants (less than 2,500 gm), in males, in black infants, in infants born to young unwed mothers of low socioeconomic status, and in infants with low birth weight for gestational age.[6] Other studies have demonstrated an association between maternal smoking, low Apgar scores, drug addiction and young unmarried mothers, and prematurity.[7-11] Black and Grether and Schulman demonstrated that the incidence of SIDS increases with decreasing birth weight.[10-11]

There appears to be seasonal variations to the incidence of SIDS. SIDS occurs more commonly in spring and winter months.[12-13] Several investigators have concluded that the seasonal variation follows that of respiratory infections.[12-14]

Investigators have attempted to utilize these epidemiologic variables prospectively with little success.[15-16] Oakley, utilizing the "at birth" scoring system, was unable

to discriminate between victims and controls.[15] Lewak attempted to apply the discriminators of Naeye to a series of infants with sudden infant deaths.[6,16]

PATHOLOGY

The diagnosis of SIDS depends on a thorough and complete autopsy. Many of the infants who die of SIDS have common findings. They frequently are found to have a frothy, blood-tinged mucus about the nose and mouth. The gross autopsy may reveal petechiae over the pleural surfaces, epicardium, and under the capsule of the thymus. The blood in the heart usually is liquid rather than clotted. The lungs frequently are noted to have congestion and edema. The stomach often contains abundant curd. Many of the infants have been noted to have retention of brown fat.[17-19]

Microscopically, 60 percent of SIDS victims have an abnormal increase in the thickness of their small pulmonary arteries.[19-20] In addition, a number of investigators have demonstrated brain stem gliosis.[21-23]

PATHOGENESIS

The aforementioned epidemiologic and pathologic data suggest that chronic hypoxia may be present in SIDS victims. Naeye prospectively demonstrated that as many as 45 percent of SIDS deaths had evidence of chronic antenatal disorders.[17,19] He postulated that these chronic maternal conditions caused the fetuses to have chronic fetal hypoxia. Myers suggested that the structural abnormalities of the brain stem were caused by antenatal hypoxia.[18]

Kinney and Filiano suggested that subtle defects in the brain stem may result in abnormalities in respiration and arousal.[25] Hunt and Brouillette suggested that the brain stem dysfunction of the SIDS victim may render the infant unable to respond to environmental stresses.[24] A number of investigators have implicated brain stem dysfunction in both apnea of infancy and SIDS.[26-27]

The hypoxic markers and the brain stem abnormalities have resulted in the apnea hypothesis of SIDS.[27] Proponents of the apnea hypothesis postulate that prolonged apnea is a major cause of SIDS, that apnea will be discernible in infants at risk for SIDS, and that respiratory recording of thoracic impedance will prospectively identify SIDS victims. While the apnea hypothesis may not explain all SIDS deaths, it may represent a subset of SIDS cases.

Recently, some reports have suggested that SIDS may be related to infant positioning.[27-32] It is common practice to place infants in the prone position, apparently to prevent aspiration of vomitus. If the infant is unable to turn his head, he may be unable to prevent suffocation, caused by compression of the soft nasal cartilage.

A recent study in the *British Medical Journal* noted that there was a higher risk of being in the prone position at the time of the SIDS death.[27] In addition, SIDS victims were more likely to have been wrapped heavily and sleeping in a warm room. These authors demonstrated that overheating and the prone position were independently associated with an increased risk for SIDS.

Fleming demonstrated that 81 percent of SIDS victims were found face down and 71 percent had their heads buried in their bedding.[28] More recently, as part of the ongoing collaborative study, three major risk factors were noted: prone sleeping position, maternal smoking, and not being breastfed. The authors concluded that if the parents reversed these three practices, the incidence of SIDS in New Zealand could be reduced from 4/1,000 to 1/1,000.[29]

In addition to brain stem abnormalities and positioning, metabolic diseases may play a role in SIDS. Some metabolic disorders, particularly medium chain acyl-coenzyme A dehydrogenase (MCAD) deficiency,[33] carnitine deficiency, and type I glycogen storage disease may play an etiologic role in SIDS.[34]

The gene for MCAD has been identified and there are a number of investigators who can recognize mutations of the gene in body tissue. Studies show as many as 10 percent of SIDS deaths may be attributed to MCAD deficiency (MCADD).[35] Numerous investigations currently are underway to determine the frequency of the gene in different populations and the relationship to SIDS.

While the common pathogenic pathway for SIDS cannot be determined, certain steps may be taken for prevention and diagnosis. Women should be encouraged not to smoke during pregnancy or allow smoking in the house after the baby is born. Further investigations should be undertaken to determine the role of prone positioning, and until that is determined, encourage supine positioning during sleep. Certain families should be encouraged to have genetic counseling and possibly undergo testing for MCADD. ■

References available upon request.

Dr. Graff is director of neonatology and Dr. Ramos is an associate director, Jersey Shore Medical Center, Neptune; and Drs. Graff and Ramos are affiliated with UMDNJ-Robert Wood Johnson Medical Center. Address reprint requests to Dr. Graff, Jersey Shore Medical Center, 1945 Route 33, Neptune, NJ 07754.

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DOCTORS' NOTEBOOK

MSNJ AUXILIARY

"Medicine Under Fire," a legislative seminar sponsored jointly by the Medical Society of New Jersey (MSNJ) and its Auxiliary, will be held on September 26, 1992, at MSNJ headquarters. Guest speakers, Robert E. McAfee, MD, American Medical Association (AMA) trustee; Congressman Dick Zimmer (R, NJ); and Congressman Robert E. Andrews (D, NJ) will discuss proposed health reform plans and other health care issues for the 1992 election.

Dr. McAfee will discuss the AMA's response to proposed health reform plans as well as "Health Access America." A surgeon practicing in South Portland, Maine, Dr. McAfee served as vice-chairman of the AMA Board of Trustees from June 1990 to 1992. He served as a member of the executive committee of the Board from 1988 to 1992. He was appointed to serve as an AMA commissioner of the Joint Commission on the Accreditation of Health Care Organizations in January 1986 and continues in that capacity. Dr. McAfee also served as president of the AMA Education and Research Foundation from 1986 to 1988, and its secretary-treasurer from 1985 to 1986.

Dick Zimmer, U.S. Representative, Twelfth District, was elected to Congress in November 1990, to replace James A. Courter. Mr. Zimmer currently is a member of the Committee on Science, Space and Technology, the Committee on Government Operations, and the Select Committee on Aging. Mr. Zimmer served as chairman of New Jersey Common Cause from 1974 to 1977, and was a member of the Republican National Committee's Advisory Council on General Government from 1978 to 1980. He also has served in both houses of the state Legislature and was chairman of the platform committee of the state Republican party in 1989.

Robert E. Andrews, U.S. Representative, First District, was elected to Congress in November 1990, in a special concurrent election to fill the vacant First District seat and a seat in the 102nd Congress. Mr. Andrews took office immediately as a member of the 101st Congress. He serves on the Education and Labor Committee, the Small Business Committee, and the Select Committee on Narcotics Abuse and Control. Prior to his election to Congress, Mr. Andrews served as the Freeholder Director of Camden County's Board of Chosen Freeholders from 1988 through 1990.

Moderating the program, which starts with registration/continental breakfast at 8:30 A.M. and concludes with lunch at NOON, will be William E. Ryan, MD, MSNJ president. Regarding the theme and content of "Medicine Under Fire" Dr. Ryan stated: "Physicians feel besieged. The Medicare program with RBRVS-initiated fee reductions has been detrimental to many practices. New initiatives in Washington suggest extension of this reimbursement mechanism plus no balance billing, federal formularies, and heavy fines for fraud abuse to be extended to the entire private sector. National health reform seems a given. In addition, oppressive regulatory measures such as the new OSHA requirements and CLIA regulations are adversely impacting physicians' practices. This symposium is intended to allow you to meet face-to-face with the people who draft these initiatives. We have invited congressmen to dialogue these issues along with Robert E. McAfee, MD, AMA trustee. We all have been complaining and looking for answers; now is the time to come and make these complaints heard and felt." ☐ Marion H. Geib, President

UMDNJ NOTES

Poll assesses health care costs and access. Some 300,000 New Jerseyans had difficulty obtaining health care in the past year because they could not afford it or had no health insurance, according to a survey commissioned by UMDNJ and conducted by the Eagleton Institute at Rutgers University. The poll also showed that specific groups of state residents—the poor, the young, the unemployed, and urban residents—have more limited access to health care than other state residents. At the same time, the poll found that 90 percent of those surveyed said they would be willing to spend their own money to support state programs to provide health care for others. The poll is the first of four quarterly polls sponsored by UMDNJ.

Researchers gain grants. Four UMDNJ researchers have been awarded grants to develop improved body-restoration techniques, including bone and ligament replacements. The grants were awarded by the New Jersey Center for Biomaterials and Medical Devices, a cooperative

research initiative sponsored by UMDNJ in coordination with Rutgers and Princeton Universities, New Jersey Institute of Technology, and Stevens Institute of Technology.

Three awards of $25,000 each went to faculty members of UMDNJ-Robert Wood Johnson Medical School, Piscataway/New Brunswick. Dr. Richard A. Berg, professor of biochemistry, received his grant to develop artificial bone on a base of collagen. The bone-like material would be used to repair bone defects and injuries. Dr. Michael G. Dunn, assistant professor of orthopedic surgery, is using animal models to develop collagen-based ligaments to replace the anterior cruciate ligament of the knee. Dr. Ralph S. Greco, professor and chief of the Division of General Surgery, is focusing on the body's response to biomaterials, particularly vascular prostheses. He will investigate the specific proteins, called integrins, that may be responsible for the body's acceptance or rejection of these commonly used devices.

An award of $10,000 to study the use of ceramics in hip replacements went to Dr. Mark Zimmerman, assistant professor of orthopedic surgery at UMDNJ-New Jersey Medical School, Newark.

Survey to assess childhood immunization in New Jersey. Physicians at UMDNJ-Robert Wood Johnson Medical School are conducting a statewide survey to discover if New Jersey infants are being vaccinated against the common communicable diseases. The survey—covering 2,300 New Jersey mothers who delivered babies during the first three months of 1990—will provide state health officials with up-to-date statistics on required childhood immunizations. The survey is funded by a $130,000 grant from the New Jersey State Department of Health (NJDOH). On the survey's two-page mailed questionnaire, the mothers, chosen randomly, are asked to indicate the date and type of vaccines their children have received and the name of the provider. Survey findings will be tabulated by geographic area and will include separate statistics on minorities. Based on current data, minority children are less likely to receive timely vaccinations. To promote a good response, the surveys are printed in both English and Spanish.

The study is being directed by Dr. George Rhoads, professor, and Dr. Nicholas Wright, associate professor, Department of Environmental and Community Medicine. ☐ Stanley S. Bergen, Jr, MD, President

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The following physicians have written to the executive offices of MSNJ seeking information on opportunities for practice in New Jersey. If you are interested in any further information concerning these physicians, we suggest you make inquiries directly to them.

Allergy

Tarun J. Shah, MD, 39C Village of Stoney Run, Maple Shade, NJ 08052. Also, pediatrics. Baroda (India) 1984. Board eligible. Board certified (PED). Solo, partnership, group. Available.

Emergency Medicine

Jayen Shah, MD, P.O. Box 251, Bordentown, NJ 08505. Baroda (India) 1991. Board certified. Available.

Gastroenterology

Steven Nadler, MD, Robert Wood Johnson University Hospital, MEB 478, GI Division, New Brunswick, NJ 08901. UMDNJ 1987. Board eligible. Board certified (IM). Group, partnership, solo. Available July 1993.

Internal Medicine

Gregory E. Broslawski, DO, 57 Westchester Terr., Annandale, NJ 08801. UMDNJ 1989. Board eligible. Available July 1993.

Nephrology

Vinitha Raghavan, MD, 7 Overbrook Rd., Upper Saddle River, NJ 07458. Guntur (India) 1981. Board certified (IM). Group or partnership. Available January 1993.

Occupational/Environmental Medicine

Jan Lieben, MD, 2200 Ben Franklin Parkway, #905 South, Philadelphia, PA 19130. Liverpool 1943. Board certified. Part time, 30 hours/week.

Oncology

Barry M. Yafe, MD, 107 Forest St., Providence, RI 02906. New York University 1984. Board certified (ONCOL and IM). Group or partnership. Available.

Surgery

Mark A. Bartolozzi, MD, Westchester County Medical Center, P.O. Box 17, Valhalla, NY 10595. New York Medical College 1987. Board eligible. Partnership. Available.

Jayen C. Shah, MD, P.O. Box 251, Bordentown, NJ 08505. Baroda (India) 1976. Also, emergency medicine. Board eligible. Hospital based or office. Available. □

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E. Chester Ridgway, III, M.D.
Professor of Medicine
Head, Division of Endocrinology
University of Colorado Health Science Center
Denver, CO

November 11, 1992
LV REMODELING: CELLULAR AND THERAPEUTIC CONSIDERATIONS
Gary S. Francis, M.D.
Professor of Medicine
Cardiovascular Division
University of Minnesota School of Medicine
Minneapolis, MN

November 18, 1992
MECHANISMS AND NEW STRATEGIES FOR TREATING AUTOIMMUNE DISEASES
David Wofsy, M.D.
Associate Professor of Medicine
Chief, Rheumatology Division
San Francisco VA Medical Center
San Francisco, CA

November 25, 1992
Thanksgiving Holiday—No Grand Rounds

DECEMBER 1992

December 2, 1992
ASTHMA BY INGESTION: ASPIRIN, SULFITE, M.S.G. AND TARTRAZINE SENSITIVITY
Ronald Simon, M.D.
Associate Clinical Professor of Medicine & Pediatrics
University of California/San Diego School of Medicine
Head, Division of Allergy & Clinical Immunology
Scripps Clinic and Research Foundation
La Jolla, CA

December 9, 1992
CHOLESTEROL REDUCTION IN PRIMARY PREVENTION: UNANSWERED QUESTIONS AND UNQUESTIONED ANSWERS
Jeremy Swan, M.D., Ph.D.
Professor of Medicine
UCLA School of Medicine
Los Angeles, CA

December 16, 1992
BREAST CANCER: DIAGNOSIS AND TREATMENT
Michael P. Moore, M.D., Ph.D.
Assistant Professor of Surgery
Cornell University School of Medicine
Sloan-Kettering Cancer Center
New York, NY

December 23, 1992
Christmas Holidays—No Grand Rounds

Hahnemann University Department of Medicine
Wednesday Medical Seminar Series
8:30 a.m.—3:30 p.m.

September 16, 1992
CRITICAL CARE OF THE IMMUNOSUPPRESSED PATIENT
Course Director: Harold L. Paz, M.D.
Guest Faculty: John M. Luce, M.D.
Paul Lankin, M.D.

October 21, 1992
PULMONARY MEDICINE
Course Director: Edward S. Schulman, M.D.
Guest Faculty: Jay A. Nadal, M.D.

November 18, 1992
MECHANISMS AND STRATEGIES FOR TREATING AUTOIMMUNE DISEASES
Course Director: Richard L. Spielvogel, M.D.
Guest Faculty: Alice Gottlieb, M.D.
Richard P. MacDermott, M.D.
David Wofsy, M.D.

December 2, 1992
ASTHMA
Course Directors: David M. Lang, M.D.
Guest Faculty: Ronald Simon, M.D.

December 16, 1992
BREAST CANCER: DIAGNOSIS AND TREATMENT
Course Codirectors: Jeffrey Brodsky, M.D.
Pamela Crilley, D.O.
Guest Faculty: Michael P. Moore, M.D., Ph.D.

Seminar Director:

Allan B. Schwartz, M.D.
Professor and Vice Chairman of Medicine
Director, Continuing Medical Education for the Department of Medicine

Location:

Classroom C (Alumni Hall)
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CONTINUING EDUCATION

DIABETES

October

1 **Diabetic Retinopathy**
8-9 A.M.—VA OP Clinic, Brick
(AMNJ and NJDOH)

9 **Diabetic Retinopathy**
8:15-9:15 A.M.—Rutgers Student Health Services, New Brunswick
(AMNJ and NJDOH)

13 **Diabetes-Related Cardiovascular Disease**
12 Noon-1 P.M.—The Mountainside Hospital, Montclair
(AMNJ and NJDOH)

15 **Prevention of Lower Extremity Amputations**
8-9 A.M.—VA OP Clinic, Brick
(AMNJ and NJDOH)

16 **Diabetes-Related Cardiovascular Disease**
8:15-9:15 A.M.—Rutgers Student Health Services, New Brunswick
(AMNJ and NJDOH)

INFECTIOUS DISEASE

October

1 **Integrating TB Management into Care of the HIV-Infected Patient**
8:30-9:30 A.M.—Community Health Care of New Jersey, Orange
(NJDOH and AMNJ)

2 **Identification and Management of Asymptomatic HIV Infection**
8:15-9:15 A.M.—Rutgers Student Health Services, New Brunswick
(NJDOH and AMNJ)

7 **Infection Control in the HIV Era**
12:30-1:30 P.M.—Kessler Institute for Rehabilitation, West Orange
(NJDOH and AMNJ)

14 **Identification and Management of Asymptomatic HIV Infection**
9-10 A.M.—Riverview Medical Center, Red Bank
(NJDOH and AMNJ)

14 **Infection Control in the HIV Era**
10-11 A.M.—The Hospital Center at Orange, Orange
(NJDOH and AMNJ)

14 **Infection Control in the HIV Era**
11 A.M.-12 Noon—Kessler Memorial Hospital, Hammonton
(AMNJ and NJDOH)

15 **Identification and Management of Asymptomatic HIV Infection**
9-10 A.M.—Dover General Hospital, Dover
(AMNJ and NJDOH)

16 **Integrating TB Management into Care of the HIV-Infected Patient**
10-11 A.M.—Marlboro Psychiatric Hospital, Marlboro
(NJDOH and AMNJ)

16 **Identification and Management of the HIV-Inderminant Infant**
12 Noon-1 P.M.—Southern Ocean County Hospital, Manahawkin
(NJDOH and AMNJ)

21 **Multiple Resistant TB**
12:15-1:30 P.M.—John Fitch Plaza, Trenton
(NJDOH and AMNJ)

21 **Infection Control in HIV Era**
10:30-11:30 A.M.—Overlook Hospital, Summit
(AMNJ and NJDOH)

22 **Integrating TB Management into Care of the HIV-Infected Patient**
12 Noon-1 P.M.—Rancocas Hospital, Willingboro
(NJDOH and AMNJ)

28 **Epidemiology and Current Trends in HIV Infections and AIDS**
1:30-2:30 P.M.—Greystone Park Psychiatric Hospital, Greystone Park
(AMNJ and NJDOH)

MEDICINE

October

2 **Visiting Professor Lecture**
1:30-5 P.M.—Saint Barnabas Medical Center, Livingston
(AMNJ)

2
16
30 **Grand Rounds**
9-10 A.M.—St. Francis Medical Center, Trenton
(St. Francis Medical Center)

6 **Common Dermatoses**
12 Noon-1 P.M.—The Hospital Center at Orange, Orange
(AMNJ)

8 **Venous Ultrasound**
7:30-9:30 P.M.—JFK Medical Center, Edison
(NJ Institute of Ultrasound)

8-10 **Critical Care Medicine Scientific Symposium**
Sheraton Society Hill, Philadelphia
(NJ Society of Critical Care Medicine)

9 **Semi-Annual Obstetrics/Gynecology Meeting**
All day—Holiday Inn, Jamesburg
(AMNJ)

13 **General Membership Meeting**
6 P.M.—Schering Corporation, Kenilworth
(Dermatological Society of NJ)

14 **Medical Problems in the Elderly**
1-2 P.M.—VA Medical Center, Lyons
(AMNJ)

15 **Advances and Controversies in Musculoskeletal MRI**

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PRESENTS

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PROGRAM

The New NHLBI Guidelines in Asthma Management	Roger C. Bone, MD
Hypoxemic Respiratory Failure	Neil R. MacIntyre, MD
ARDS and Multi-Organ Failure: A Current Perspective	Roger C. Bone, MD
Modern Mechanical Ventilation: A Practical Approach	Neil R. MacIntyre, MD
Lung Transplantation: Recipient Selection and Expectations	David M. F. Murphy, MD
The Clara Falk Franks Lecture - Tuberculosis: Update 1992	Henry Masur, MD
Lung Cancer: When Is It Malpractice to Fail to Diagnose?	E. James Potchen, MD
Life-Threatening Pulmonary Infections: Diagnosis and Antibiotic Selection	Henry Masur, MD
Diffuse Lung Disease: Pearls & Pitfalls	Mervyn Felerstein, MD

For information contact: **Center for Bio-Medical Communication, Inc.**
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7:30-10 P.M.—Saint Barnabas Medical Center, Livingston
(AMNJ)

17 **New Practice Program**
8:45 A.M.-4 P.M.—MSNJ headquarters, Lawrenceville
(MIIX and AMNJ)

20 **New View of Distal Renal Tubular Acidosis**
9 A.M.—Overlook Hospital, Summit
(AMNJ and Nephrology Society of NJ)

22 **Scientific Meeting**
6:30-9:30 P.M.—The Manor, West Orange
(Head and Neck Oncology Section, AMNJ)

23-24 **17th Annual Orthopedic Society Symposium**
Somerset Marriott Hotel, Somerset
(NJ Orthopedic Society)

28 **Medical History Society of New Jersey**
3:30-9 P.M.—Nassau Club, Princeton
(AMNJ)

PSYCHIATRY

October

7 **Psychiatric Case Conference**
1:30-2:30 P.M.—Greystone Park Psychiatric Hospital, Greystone Park
(AMNJ)

15 **Monthly Meeting**
6 P.M.—Hackensack Medical Center, Hackensack
(NJ Psychoanalytic Society and AMNJ)

16 **Journal Club**

21 2:30-4 P.M.—Greystone Park Psychiatric Hospital, Greystone Park
(AMNJ)

23 **Mental Disorders in the Elderly**
8:15 A.M.-4 P.M.—The Hyatt New Brunswick
(AMNJ)



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3:00-3:30 Contour electrocardiography: Easy and difficult readings—***Steven J. Nierenberg, M.D.***

3:30-4:00 Cardiac arrhythmias: Common and uncommon recordings—***Charles D. Gottlieb, M.D.***

4:00-5:00 Slides of ECGs (unknowns) will be presented and discussed
Panel Discussion—***Michael S. Feldman, M.D., Terry Langer, M.D., Stephen J. Nierenberg, M.D., Mark Preminger, M.D.***

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IN MEMORIAM

JOSEPH B. GORDON

At the grand age of 90, Joseph Berkeley Gordon, MD, died on January 4, 1992. Dr. Gordon was born on July 22, 1901, in Richmond, Virginia. He graduated from the Medical College of Virginia, in 1926. Dr. Gordon completed an internship at Sheltering Arms Hospital, Richmond, in 1926, and at the United States Naval Hospital, New York, in 1927. He received his New Jersey medical license, in 1929. Dr. Gordon specialized in forensic psychiatry. During his 61 years in the medical profession, Dr. Gordon was the medical director of Marlboro Psychiatric Hospital; medical officer at the State Home for Boys, Jamesburg; affiliated with Monmouth Medical Center, Long Branch and Fitkin Memorial Hospital, Neptune; past-president of our Monmouth County component in 1949 and of the New Jersey Psychiatric Association; member of the American Medical Association; and fellow of the American Psychiatric Association. Dr. Gordon served in the United States Navy during World War I. Dr. Gordon resided in Marlboro Township and Rumson.

BERNARD M. HALBSTEIN

A 1935 Boston University School of Medicine graduate, Bernard Mark Halbstein, MD, died on November 27, 1991. Dr. Halbstein was born in Lynn, Massachusetts, on July 13, 1910. Dr. Halbstein served an internship at St. Luke's Hospital, New Bedford, Massachusetts, and a residency at Cincinnati General Hospital, Ohio; he did graduate work at the State University of Iowa. Dr. Halbstein specialized in orthopedic surgery. He was director of the department of orthopedics and president of the medical staff at Monmouth Medical Center, Long Branch, and president of the New Jersey Chapter of the American College of Surgeons. Dr. Halbstein was affiliated with Riverview Hospital, Red Bank; Allenwood Sanatorium; Jersey Shore Medical Center, Neptune; and Kimball Medical Center, Lakewood. Dr. Halbstein was a member of our Monmouth County component and of the American Medical Association; a diplomate of the American Board of Orthopedic Surgery; and a fellow of the American College of Surgeons. Dr. Halbstein received a Bronze Star Medal for his military service during World War II.

DOUGLAS A. HAMMETT

We regret to inform you of the death of Douglas Alexander Hammett, MD, on Janaury 1, 1992, at the untimely age of 58. Dr. Hammett was born on March 2, 1933, in New York City. Dr. Hammett was awarded a medical degree from the University of Toronto, Canada, in 1960. He completed an internship at Lenox Hill Hospital, New York, in 1961, and a residency at Hunterdon Medical Center, Flemington, in 1962. He received his license to practice medicine in New Jersey in 1962. Dr. Hammett was a general practitioner who practiced in Sparta and was chief at Newton Memorial Hospital. Dr. Hammett was a diplomate of the American Board of Family Practice and a member of our Sussex County component and of the American Medical Association.

MARY C. JASTI

We regret to inform you of the death of Mary Carla Jasti, MD, of Princeton, at the untimely age of 50, on January 29, 1992. Dr. Jasti was born on January 2, 1942, in India and was awarded a medical degree from Osmania Medical College, Hyderabad, India, in 1964. She completed a residency at Kingsbrook Jewish Medical Center and at Veterans Administration Medical Center, both in New York. She received her New York and New Jersey medical licenses in 1976 and 1980, respectively. Dr. Jasti specialized in cardiology and internal medicine; she practiced in India, Brooklyn, and Kendall Park, and was affiliated with The Medical Center at Princeton and Brookdale Medical Center, New York. Dr. Jasti was a diplomate of the American Board of Internal Medicine, a fellow of the American College of Angiology, and a member of our Middlesex County component.

SAMUEL G. LOMAN

Born in New York City on May 7, 1906, Samuel Gordon Loman, MD, died on January 11, 1992. Dr. Loman resided in Cresskill. He was awarded a medical degree from the Faculty of Medicine University of Glasgow, Scotland, in 1934. The following year he received his New Jersey medical license. A family practitioner, Dr. Loman maintained a practice in Cresskill and was on staff at Englewood Hospital from 1936 until his retirement. He was the surgeon for the Cresskill police and fire departments; health officer for the Cresskill public school system; recipient of the Medical Society of New Jersey Golden Merit Award; and member of our Bergen County component and of the American Medical Association. Dr. Loman was a United States Army veteran of World War II. In 1986, the Cresskill ambulance corps building was named in his honor.

GEATANO A. MASCARA

We have received word of the death of Geatano Anthony Mascara, MD, on October 20, 1991. He was 79 years old. Dr. Mascara was born on March 4, 1912, in Italy. He was awarded a medical degree from New York Medical College, Flower and Fifth Avenue Hospital, New York, in 1937. After serving in the United States military during World War II, Dr. Mascara received his New Jersey medical license in 1945. Dr. Mascara resided and practiced in Vineland; he was a general practitioner. Dr. Mascara was attending at Newcomb Hospital, Vineland. He was a member of our Cumberland County component and of the American Medical Association.

WILLIAM L. RUMSEY, JR

William Lacy Rumsey, Jr, MD, passed away on January 9, 1992. Dr. Rumsey was 80 years old. He was born on July 8, 1911, in White Plains, New York. Dr. Rumsey was awarded a medical degree from Harvard Medical School, Boston, in 1938. Dr. Rumsey completed an internship at Lenox Hill Hospital, New York, and a residency at Children's Hospital, Boston. Dr. Rumsey was a pediatrician and was affiliated with John E. Runnels Hospital, Berkeley Heights; Rahway Hospital; Alexian Brothers Hospital, Elizabeth; St. Elizabeth Hospital; Saint Michael's Medical Center, Newark; and Elizabeth General Medical Center. Dr. Rumsey was a diplomate of the American Board of Pediatrics; a member of our Union County component and of the American Medical Association; and a fellow of the American Academy of Pediatrics.

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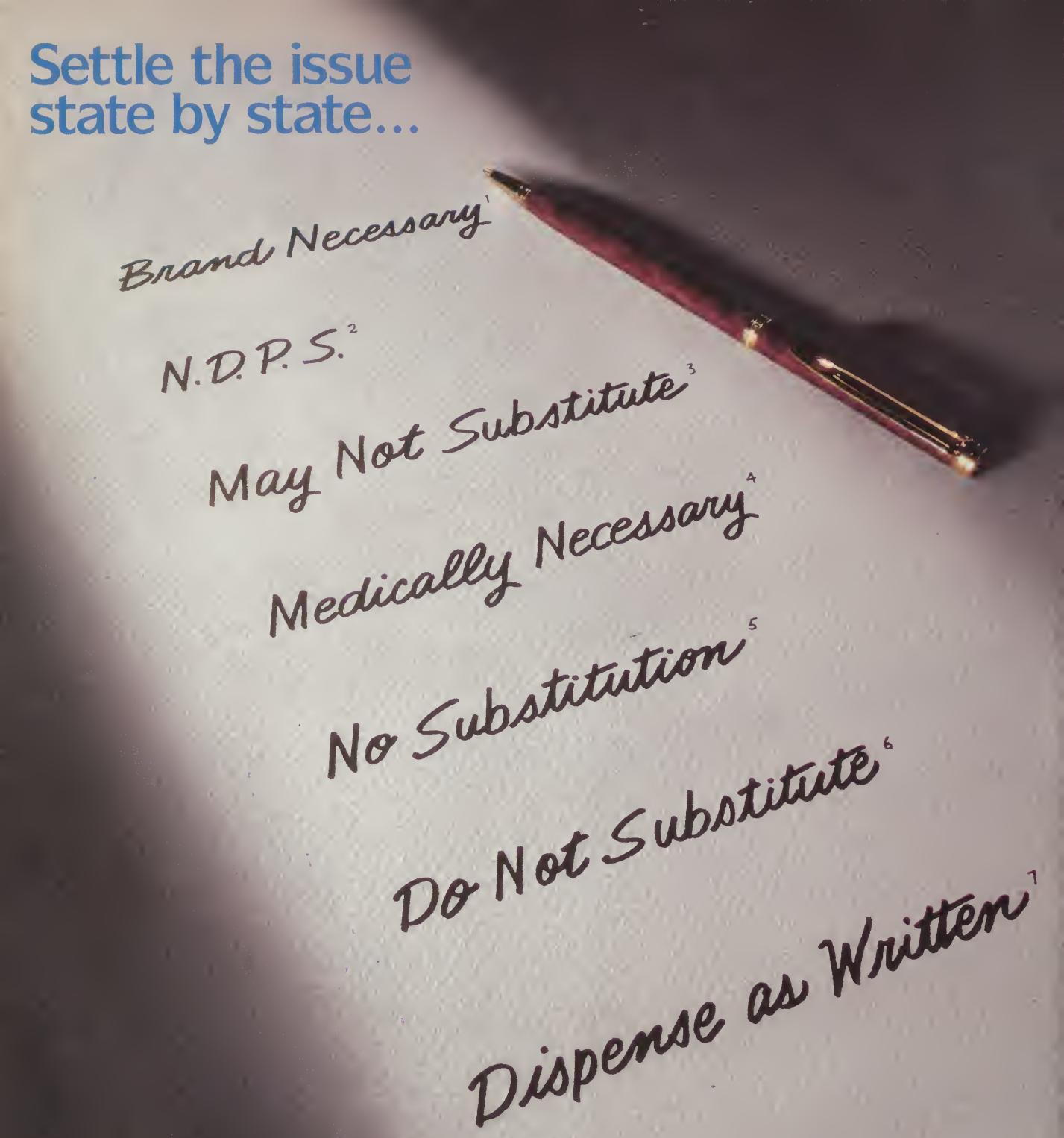
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Newswatch

NEW STATE HEALTH COMMISSIONER...

On September 3, 1992, State Health Commissioner Frances Dunston, MD, MPH, announced her resignation effective mid-October. Dr. Dunston will be succeeded by Bruce Siegel, MD, in the role of acting commissioner--an appointment that does not require Senate approval.

Dr. Dunston's tenure, which began in April 1990, was marked by acrimony over the State Health Plan, an increasing role for health policy in partisan politics, but less controversy over the New Jersey State Department of Health's leadership of the fight against the AIDS epidemic.

Dr. Siegel has served under Dr. Dunston as director of policy and research and as one of three deputy commissioners. Dr. Siegel led the effort to develop Phase 1 of the State Health Plan, which provoked protests against recommended closures of selected hospitals and community hospital pediatric units, among other issues.

RISE IN CHILD ABUSE COMPLAINTS EXPECTED...

As the national and regional broadcast media focus on child abuse, physicians may be called on to play a more active role in situations of family violence. The American Medical Association (AMA) leads a well-orchestrated Physicians' Campaign Against Family Violence. As part of that effort, the AMA has developed diagnostic and treatment guidelines for domestic violence, child sexual abuse, and child physical

abuse and neglect. To obtain booklets containing these guidelines, contact Karen Monsees, MSNJ, 1/609/896-1766.

MEDICARE LIMITING CHARGE CHALLENGE...

Trial began the week of September 14, 1992, in the case of Stewart (Copeland) versus Sullivan in the federal district court in Newark, with Judge Nicholas Politan presiding. The AMA and the Medical Society of New Jersey have entered the case amicus on behalf of the right of physicians and patients to contract outside of the Medicare limiting charge program. The decision will be reported in upcoming issues of NEW JERSEY MEDICINE.

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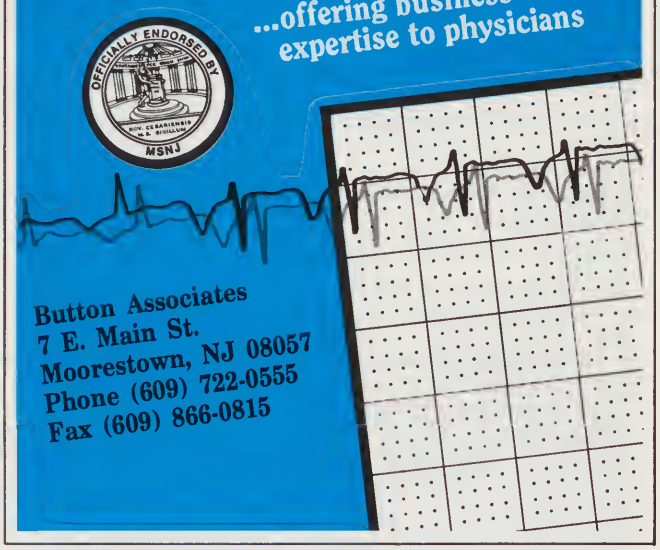
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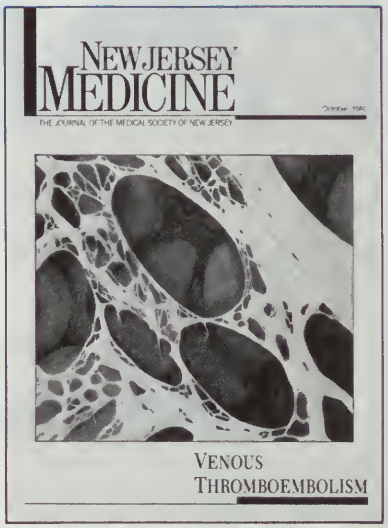
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The Cover

Drs. Rehm, Spence, and Ross discuss the etiology, diagnosis, treatment, and prophylaxis of venous thromboembolism in trauma patients. Cover illustration: Beth A. Starkey.

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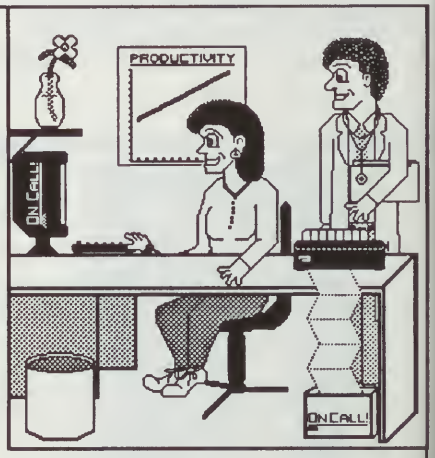


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MSNJ NEWSLETTER

HEALTH PROFICIENCY TESTING PROGRAM

CLIA-88, the Clinical Laboratory Improvement Amendments of 1988, mandates that all facilities performing laboratory testing for the assessment, diagnosis, prevention, or treatment of human disease must be federally certified or receive a certificate of waiver. CLIA-88 became effective September 1, 1992, and extends certification requirements to virtually all physician office laboratories (POL) as well as to all other sites. One of the requirements for certification is that laboratories must enroll in a Health and Human Services (HHS)-approved proficiency testing program such as the one offered by the New Jersey State Department of Health's (NJDOH) Clinical Laboratory Improvement Service (CLIS).

Because many previously unregulated laboratories now will have to undergo certification, HHS has delayed mandated proficiency testing enrollment until January 1, 1994. One of the reasons for the delay was to afford laboratories the opportunity to enroll and obtain experience with proficiency testing prior to the date when unsatisfactory performance would lead to compliance action. For this reason, enrollment and participation in an approved proficiency testing program for 1993 could prove very beneficial in familiarizing POL staff with the process.

NJDOH's proficiency testing program is among a limited number of programs throughout the nation approved for enrollment of CLIA-88 certified laboratories by the U.S. Health Care Financing Administration. For information about the CLIS Proficiency Testing Program, contact Rose Ann LaFisca, NJDOH, CLIS, CN 360, Trenton, NJ 08625-0360.

PHARMACEUTICAL PROGRAM

Physicians seeking medications at no charge for needy patients can refer to a directory of free pharmaceutical programs compiled by the Pharmaceutical Manufacturers Association (PMA). To obtain the listing, write, 1992 Director of Prescription Drug Indigent Programs, PMA, 1100-15th Street, NW, Washington, DC 20005. For information on specific programs, call the tollfree hotline, 1/800/PMA-INFO.

VOLUNTEER FOR HEALTH EDUCATION

Liberty Science Center (LSC) is the nation's newest science center devoted to informal education through hands-on exploration. Located on a 17-acre site at Liberty State Park in Jersey City, LSC's four stories encompass three distinct exhibit areas: environment, invention, and health. LSC's mission is to make significant contributions to science literacy among the general public by giving people of all ages the opportunity to experience science through exciting and fun interactive activities.

Volunteers are a key part of the educational team. Volunteers play a vital and visible role by providing guests the opportunity to explore the world of science. Physician volunteers are needed for a variety of exhibits: Bodies in Motion exhibit; Making Sense exhibit; Lifestyles exhibit; Your Heart exhibit; Medical Equipment exhibit; Laboratory exhibit; and The Human Body exhibit.

Volunteers receive a wide array of benefits including educational programs, lounge privileges, inclusion in some staff events, store discounts, and a comprehensive, year-round recognition program.

The excitement of being a part of the LSC team is building fast. For more information on volunteering, call the Volunteer Services Office at 1/201/451-0006.

MEDICAL HISTORY MEETING

There will be a meeting of the Medical History Society of New Jersey on October 28, 1992. The meeting will be at the Nassau Club of Princeton, from 3:30 P.M. to 9 P.M. Featured speakers are: Allen B. Weisse, MD; Kenneth Swan, MD; William Sharpe, MD; and Ross Mullner, PhD, MPH. For additional information, contact Lisa Fleischer, the Academy of Medicine of New Jersey, 1/609/896-1717.

GRADUATE EDUCATION OF INTERNATIONAL PHYSICIANS

In a survey of New Jersey hospitals, the Medical Society of New Jersey (MSNJ) documented the prevalence of international medical graduates (IMGs) among applicants for residency positions. In 13 of the 20 responding teaching hospitals, more than three-fourths of applicants were IMGs. However, IMGs actually filled three-fourths of the slots in only eight of these hospitals. The results may give credence to the view that IMGs face a difficult time obtaining opportunities in graduate medical education. MSNJ's Committee on IMG's conducted the survey.

AMA FEE POSTING POLICY

Physicians are expected to post in their waiting rooms their regular, nondiscounted fees for the ten procedures that the individual physician most frequently performs, under a new policy approved by the Board of Trustees of the American Medical Association. In addition, physicians are expected to make a list available on request of most or all of their regular fees.

This type of information may help physicians demonstrate their responsiveness to concerns about health care costs. In addition, price information is considered an essential component of an effective marketplace and, therefore, a pillar supporting competition as the alternative to government regulation. The mere presence of posted fees also could help create a positive image for the physician in the eyes of patients.

COST-PLUS 10 PERCENT RULE STAYED

On August 12, 1992, the State Board of Medical Examiners extended its stay, or delay, of a new regulation prohibiting physicians from charging patients more than 10 percent above the physician's own cost of ancillary drugs, goods, and devices. The regulation has been challenged in court by the New Jersey Academy of Ophthalmology and Otolaryngology. The stay is expected to remain in place until a court decision is reached or the Board decides to change the regulation.

BICYCLE HELMET LAW PROMOTED

In July 1992, New Jersey became the first state to require child bicyclists to wear safety helmets. Compliance with the law could save the lives of five to ten New Jersey children under the age of 14 every year. A kit of materials has been assembled by the state's Bicycle Law Promotion Coalition. For information, contact Karen Monsees at MSNJ executive offices, 1/609/896-1766.

In 1977, the Medical Inter-Insurance Exchange promised to return the seed capital provided by its founding members. Our financial strength has enabled us to keep that promise. The New Jersey Insurance Department recently approved our request to redeem another set of outstanding subordinated loan certificates.

After this second round of redemptions, MIIX will have repaid over 50% of all certificates issued in capitalizing the company.

We no longer require subordinated loan certificates for new policyholders, and we will continue to redeem the certificates as state regulators approve our plans.

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MALPRACTICE AND OTHER CASES

Nerve and neurosurgery. From Florida comes word of a physician's revenge. During a malpractice trial the defendant neurosurgeon noticed that the plaintiff repeatedly performed movements that were inconsistent with the claimed injuries. After losing a $2.25 million verdict, the physician hired a private detective who videotaped the patient, a former New York City police officer, performing physical acts that showed an absence of neurologic damage—such as operating the yacht purchased with the proceeds from the trial. A jury convicted the once victorious plaintiff and his wife of grand theft and conspiracy, which carry a maximum 75-year sentence.

Supreme Court backs Cippolones. On June 24, 1992, the U.S. Supreme Court issued a divided decision in a major health case from New Jersey—and the result was a major defeat for cigarette manufacturers. The case involved Rose Cippolone, who died in 1984 after 42 years of smoking. Mrs. Cippolone, her late husband, and her surviving son sued the Liggett Group, claiming that its products caused her fatal lung cancer. The Cippolones asserted five alternative theories of liability: design defect; failure to warn; express warranty; fraudulent misrepresentation; and conspiracy to defraud.

After an initial appeal, a federal district court jury found the defendants liable for breach of express warranty. The jury also found that the Liggett Group violated its duty to warn, but held Mrs. Cippolone responsible for 80 percent of her injuries, thus barring recovery under this claim. The jury found for the defense on the fraudulent misrepresentation and conspiracy counts, and the design defect claim was struck for reasons that no longer were at issue.

The issue for the nation's high court was whether the U.S. Congress, in enacting cigarette labeling legislation in 1965 and 1969, pre-empted state law in this area, so that tobacco companies are not liable to consumers under common law. The federal legislation expressly prohibited the states from limiting cigarette advertising, in return for printing the prescribed "WARNING" on each package. A four-member plurality, led by Justice John Paul Stevens and also including Chief Justice William H. Rehnquist, Byron R. White, and Sandra Day O'Connor, ruled that the legislation did not prohibit states from holding manufacturers liable for breach of express warranty or conspiracy to defraud. The plurality did agree with the defendants that claims of failure to warn and fraudulent misrepresentation, for the most part, were pre-empted.

Justice Harry A. Blackmun wrote an opinion joined by Anthony M. Kennedy and David H. Souter that rejected the plurality's compromise and argued that none of the claims was pre-empted. At the other end of the spectrum, Justice Antonin Scalia, joined by Clarence Thomas, found total pre-emption.

People injured from smoking now are free to bring actions against cigarette manufacturers on limited grounds, although cases will be hard to prove. And, apparently the Cippolone family will recover damages after all.

New evidence rule on treatises. The state's high tribunal also has produced an important health-related decision, adopting a new rule of evidence to expand access to medical textbooks and scientific articles in malpractice cases. On July 8, 1992, the New Jersey Supreme Court unanimously adopted a federal rule of evidence that permits learned treatises to be used when questioning an expert witness, so long as the witness, another expert witness, or the court through judicial notice establishes the treatise as a reliable authority.

In the case at issue, three members of a hospital's house staff in turn inserted a 5.0-gauge catheter into the umbilical artery of a 730 gram newborn; each time the catheter was withdrawn when the baby's leg became discolored. Circulatory damage to the leg proved permanent; toes auto-amputated, and eventually the leg, which has not grown properly, may have to be amputated. In cross-examining a defendant and an expert witness for the defense, the plaintiff's attorney tried to introduce statements in a neonatology textbook claimed by the defendant to be the authority for the use of the large catheter. Likewise the plaintiff tried to introduce an article published in *Neonatal-Perinatal Medicine* and an article published in *Pediatrics* that similarly advised "keeping the size of the catheter as small as practicable" to prevent complications. However, the witnesses declined to call these sources "authoritative." The trial judge then prohibited use of the literature, citing the 1956 Ruth v. Fenchel decision that permitted the use of a treatise only in questioning a witness who agrees that the treatise is a "recognized and standard authority on the subject."

The Supreme Court reversed an Appellate Division decision and the judgment of the trial

court, where a jury found for the defendants. Under Ruth, said the justices, a witness does not have to call a source "authoritative" in order for the source to be referenced in questions put to the witness. Moreover, to prevent similar courtroom situations from arising, the court adopted Federal Rule 803(18) in New Jersey courts prospectively—and for further proceedings in the case at bar.

Utilization reviewer burnout. In a recent North Carolina case a former utilization review clerk was denied industrial compensation for stress that, the clerk claimed, was the cause of her resignation. Commenting on the case, *Hospital Law Newsletter* remarked that "the nature of the work is such that stress, leading to burnout, can well be attributable to such work." Something to keep in mind in utilization review communications.

ANTITRUST

Antitrust threats to physicians. In a written and oral presentation to the annual meeting of the American Association of Medical Society Executives, Attorney Jack R. Bierig of Chicago outlined the hazards confronting physicians under antitrust law. Mr. Bierig's warnings were implicitly confirmed by another presenter, Federal Trade Commission (FTC) general counsel James Spears.

As Mr. Bierig noted, antitrust actions may be brought by the U.S. Justice Department, the FTC, state attorneys general, and private plaintiffs. Awards include treble damages. Courts occasionally will order payment of attorney fees to successful plaintiffs but do not order payment of attorney fees to successful defendants. Insurance ordinarily does not cover antitrust actions. The government rarely settles, often seeks restitution and other "sweeping" penalties, and lately has embarked on criminal actions that pose penalties of imprisonment, fines, stigmatization, and loss of the license to practice.

Dangerous liaisons listed by Mr. Bierig include: boycotts of third-party payers and concerted negotiations with a payer over fees; boycotts of hospitals or other physicians ("a quick trip to the slammer"); agreements to set prices by physicians who share no risk; joint ventures and referral agreements; mergers under certain conditions; exchanges of information about fees or other economic factors; peer review of fees, when the fee that was charged is published or when there are no due process protections; and improper credentialing decisions, such as denying privileges to physicians who compete against the hospital.

Economic credentialing by hospitals is receiving increasing attention, as noted by conference speakers and various other sources, especially since *Hospitals* magazine reported more than two-fifths of surveyed hospital chief executive officers said they may resort to economic credentialing of physicians within the next five years. Generally, legal experts find no clear impediment to terminations of privileges of physicians who fail to bring revenue-bearing cases to the hospital.

MALPRACTICE TIPS

Poor communication. As the July issue of *Loss Minimizer* points out, and numerous other sources have confirmed, ineffective communication with patients generates malpractice suits. The newsletter observes that a failure to explain a complication, seeming lack of caring, and rudeness lead to anger that may be at the root of as many as 95 percent of malpractice claims. A failure to describe the potential of adverse outcomes leads to unrealistic expectations and a potentially wide gap between expectation and outcome. Criticism by another practitioner can lead to doubts about a physician's competence.

Communication skills, including marketing, will be the subject of an upcoming series of seminars held at the executive offices of the Medical Society of New Jersey. Contact Addie Holden, 1/609/896-1766, for information.

Injuries to colon. Primary surgical repair is replacing proximal colostomy as the treatment of choice for most patients with grade I or II colonic injuries, while colostomy remains the treatment of choice for patients whose grade III injuries may involve organ trauma, hypotensive shock, and contamination of the peritoneal cavity, according to *Personal Injury Newsletter*. For both procedures the primary risk is wound infection. Other complications include intra-abdominal abscess, septicemia, renal failure, and fecal fistula.

Laparoscopic cholecystectomies. "Tell malpractice insurers to get their reserves up, because the cases are coming," one plaintiff's lawyer has told *Medical Liability Monitor* about suits involving laparoscopic gallbladder surgery. Nevertheless, the newsletter does not foresee an "explosion" of such suits. The only common complication, it reports, is injury to the common bile duct. Most observers agree that the benefits of the procedure far outweigh the risks.

There is, however, reason for concern. The newsletter quotes Adam P. Wilczek, vice-president for risk prevention at the Medical Inter-Insurance Exchange, as saying, "We are monitoring the situation very carefully." One possible exposure is that the surgeon may not realize quickly enough that the bile duct has been damaged. New York State's Health Department has sought to assure that only qualified physicians perform the procedure. The department's

new regulations require the surgeon to be qualified for certification by the American Board of Surgery, specifically credentialed in the procedure, trained in a laparoscopic practicum, and experienced in a specified number of operations as an assisting and then as the operating surgeon.

MALPRACTICE VERDICTS

Breast cancer diagnosis. In 1987, a woman was diagnosed with breast cancer, and no lymph nodes were involved. Fifteen months later, the patient's gynecologist observed a small lump below the incision and advised her to return to her general surgeon for a diagnosis. The surgeon apparently believed the patient had costochondritis involving an inflammation of rib cartilage. When the lump demonstrably increased in size and pain developed in a shoulder and hip, the patient returned to the surgeon. A later biopsy was positive; the cancer had metastasized to the bone, and the patient died of breast cancer at age 41, 1½ years after first visiting the surgeon for diagnosis of the lump.

In a malpractice action against the surgeon, claims were made for emotional distress on the part of the patient and for intangible losses to her family. However, the family conceded that an earlier diagnosis would not have prevented death and did not sue for physical pain and suffering.

An oncologist testified for the plaintiff that repeat scans were indicated, because more than a year had passed since the last scan and because the patient's original cancer was a poorly differentiated carcinoma. The expert said that the delay in diagnosis increased the risk of harm to the patient; with proper diagnosis, said the expert, there was a 50 percent chance of survival for five years. The delay did not affect longevity, claimed the defense. Pointing to a letter he wrote to the gynecologist, the defendant said that the patient ignored his instructions to return if the lump grew—an assertion disputed by the plaintiff.

The jury in this New Jersey case found for the plaintiff that the defendant's alleged negligence increased the risk of harm and was a substantial factor in the patient's death. The jury estimated that there had been a 55 percent chance of survival for 2 years. But, said the jury, the patient herself was 45 percent comparatively negligent. The jury found damages of $100,000 for emotional distress to the patient and $75,778 for wrongful death that included the losses, such as loss of guidance, for the patient's husband and three children, who at the time of death were 22, 19, and 13 years old, respectively. Molded accordingly, the award was for $53,172.

Complications of cataract surgery. For more than two years following cataract surgery at age 75, a woman saw halos and flashes of light and eventually became virtually blind in the affected eye. She sued the ophthalmologist on a number of grounds, including failing to suture the iris properly after an iridectomy was created, negligently placing the lens anteriorally rather than posteriorally, causing damage to the posterior chamber during surgery, failing to record the complications, failing to complete the surgery on the scheduled day, and failing to inform the patient of the risks. The patient alleged damages that included the effects of falls induced by a loss of depth perception, an inability to continue her lifelong hobby of knitting, and depression. Her subsequent physician served as her expert medical witness, and her expert psychologist, like her, was blind in one eye.

Early in the procedure a bulging of the vitreous, a common occurrence, caused the posterior capsule to break, leading to bleeding and making implantation of the posterior chamber lens impossible, explained the defendant. But, if this is why the anterior placement was necessary, countered the plaintiff, why does the medical record not so indicate? The New Jersey jury's award was for $130,000.

Pediatric pericarditis. An 11-year-old boy experienced chest pain for seven to ten days before seeing a pediatrician, who diagnosed costochondritis and prescribed Advil™. Three weeks later, after numerous conversations between the pediatrician and the boy's mother, the patient returned with the same complaint and an earache, and the pediatrician noted tachycardia, which he believed to be associated with medication prescribed for narcolepsy. Several days later, and following a visit to a covering physician who recommended a CBC, the pediatrician admitted the patient for dehydration.

During the hospital stay pericarditis was diagnosed; a pericardectomy was performed. The patient was hospitalized for ten days for depression, which the plaintiff contended was caused by the surgical scar and distress from the episode. A malpractice suit was brought against the pediatrician in New Jersey.

The defendant told the court that he, in fact, had admitted the patient for suspected pericarditis as well as dehydration, after observing sounds on the pericardium that had not been noticed previously. The defendant further argued that chest pain in a child of that age is rarely cardiac in nature. He suggested that the depression resulted from the child's relationship with his clinically depressed mother, and he disputed that the psychiatric admission, as alleged, was tied to the possiblity of suicide because the discharge was based on a negative finding of suicidal tendencies. The jury found for the defendant.

MALPRACTICE POLICY DEVELOPMENTS

Consumer suits against providers. One downside effect of the marketing of physician services is the prospect of suits for unfair and deceptive practices brought under consumer protection acts. Iatrogenic injuries, notes *Medical Malpractice Reports,* generally form the basis of the consumers' allegations. Advantages of suing under the consumer laws, rather than for malpractice, include avoiding the need for expert witnesses, longer statutes of limitations, higher damages, and possible payments for attorney fees.

Reports to National Practitioner Data Bank. The Federal Department of Health and Human Services is concerned that reports to the National Practitioner Data Bank are far fewer than anticipated. In the July 1, 1992, issue of the *Journal of the American Medical Association,* Bureau of Health Professions director Fitzhugh Mullan lamented that reports ran only half their expected volume for the year ending August 31, 1991. Of the 14,000 reports, 85 percent were for malpractice payments, and the remainder were for adverse clinical privilege actions.

Awards soar in California. In 1991 payments for malpractice cases exceeding $1 million increased 50 percent, payments for cases exceeding $100,000 reached all-time highs, and payments for anesthesia cases rose 69 percent. *Medical Liability Monitor* reported this from the California Medical Malpractice Large Loss Trend Study.

HEALTH CARE FINANCING

Predicting the effects of RBRVS. A vice-president of Lewin-ICF, a leading "inside-the-Beltway" health care consulting firm, has updated predictions about the effects of resource-based relative value scales (RBRVS) for Medicare physician fees. Writing in the *Group Practice Journal,* Allen Dobson, PhD, sees significance in the Health Care Financing Administration's (HCFA) use of small groups of insurer medical directors and specialty society representatives to modify the code values obtained by independent researchers. Dr. Dobson notes, though, that the specialist representatives have found it difficult to match the work content of their contested codes with the work content of codes in other specialties.

Dr. Dobson sees volume issues as the main source of contention. To resolve issues of volume performance standards—that led HCFA to propose increases for surgical fees simultaneously with RBRVS-induced decreases for surgical fees—HCFA would have to make complicated calculations involving a "level of micromanagement" that Dr. Dobson finds "almost inconceivable."

The predictions include: quality and severity adjustments for fees; problems in access to care among senior citizens; effects on the supply of physicians; greater popularity among younger physicians of large group practices; adaptation of RBRVS to private insurance; government "underfunding" of RBRVS that will force physicians to face financial risks or shift costs to other payers; losses by academic medical centers; and changes in physician-patient relationships. Uncertainty and risk, the writer admonishes, are "the inevitable result" of fee schedules based on averages.

Dr. Dobson suggests that hospitals will need to involve physicians more heavily in decision making in order to obtain sufficient physician referrals.

Genetic testing of insurance applicants. Should insurance companies be permitted to require genetic testing of applicants for life and health insurance? Yes, say insurers, so that high-risk individuals are prevented from paying low premium costs that do not reflect the individuals' risk. Maybe not, says Robert Lowe in a *Drake Law Review* article, because adverse selection is not the great problem that insurers depict, because genetic testing prevents disease, and because good risks necessarily subsidize bad risks. As reviewed in the *Personal Injury Newsletter,* Mr. Lowe's article calls for limited regulation to protect against adverse selection, such as allowing tested persons to purchase insurance only up to set limits.

AIDS

State liable to infected nurse. New York State was held liable in state court on July 14, 1992, for the apparent infection with HIV of an anonymous nurse caring for an unruly prisoner. During a struggle, the nurse was jabbed with a hypodermic needle containing the HIV-positive prisoner's blood. Corrections officers failed to intervene in the struggle. An appeal is expected to focus on the question of the hospital's liability. ☐ James E. George, MD, JD; and Neil E. Weisfeld, JD, MSHyg

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BOOK REVIEWS

KEY TOPICS IN ANESTHESIA

TM Craft and PM Upton. Oxford, UK, BIOS Scientific Publishers, Ltd., 1992. The authors note that this book adopts a problem-oriented approach to clinical tasks. They emphasize that certain topics occur more frequently under Board examination than in actual clinical practice. Drs. Craft and Upton have attempted to edit a textbook for general use, but especially for those persons to use while preparing for professional examinations. To this end, the editors have succeeded admirably.

The book covers 100 topics ranging from monitoring, AIDS, and physics to scavenging systems. It is a laudable book in that each topic is well researched and outlined. The authors note that this work is not meant to be comprehensive, and for those who feel coverage of a topic might appear inadequate for specific needs, the authors have annotated lists of further reading and related topics of interest.

This book is more than adequate for a general knowledge of the subject—to avoid that altogether too-frequent "blank look" when questioned by a Board examiner, certainly adequate for an attending to refresh himself upon a subject, and definitely adequate for a resident in anesthesia. The book is concise with an eminently readable format and merits a place on every anesthesiologist's bookshelf. ☐ Stanley Bresticker, MD

THE OFFICE MANAGEMENT OF DIGESTIVE DISEASES

Joseph Danzi, MD, and Joseph Scopelliti, MD. Philadelphia, PA, Lea & Febiger, 1992. I found this book to be an extremely well-written textbook; it concentrates solely on the office management of gastrointestinal (GI) disorders and complaints. Unlike other textbooks of gastroenterology that focus on inpatient management of GI disease containing long and involved discussions of pathophysiology, this reference has brief, useful, and intelligible discussions of pathophysiology.

The book contains 21 chapters; 233 pages with a complete index. The excellent reference tables, logarithms, and photographs are useful. A chapter discussing the care and disinfection of flexible endoscopes is included.

I especially would recommend this book to primary care physicians, housestaff, and GI fellows. However, even the experienced gastroenterologist would find this book a valuable addition to his library. I highly recommend this book. ☐ Steven C. Fiske, MD

A PRACTICAL GUIDE TO ULTRASOUND OF FETAL ANOMALIES

Frederick Hegge. New York, NY, Raven Press, 1992. With the early detection of fetal anatomic anomalies possible, this state-of-the-art guide to sonographic evaluation will prove highly useful to the technologist and to the physician.

This book follows a text-atlas format. The text portion, which encompasses the beginning chapters, offers a short, didactic review of the diagnosis of fetal anomalies. Dr. Hegge describes his protocol to the basic obstetrical scan. High-quality images accompany discussions of each organ system. A chapter entitled, "Scanning Techniques," provides the novice with the necessary information to avoid common pitfalls. Charts supply

the reader with a quick reference for determining the onset of each type of fetal anomaly.

The second part of this paperback comprises an atlas of various congenital abnormalities. A chapter on each major organ system contains representative malformations. The section on the kidneys presents images of the various etiologies of the hydronephrotic kidneys and bladder obstruction. Types of dyplasias as well as agenesis and the different kinds of cystic kidneys also are included.

The combination of multiple scans and succinct explanations makes this a handy text for the prenatal diagnosis of diseases. Sonographers will want to keep this book within easy reach. ☐
Neil B. Horner, MD

THE PROSTATE BOOK

Stephen Rous, MD. New York, NY, W.W. Norton and Co., Inc., 1992. This seems to be the year of the prostate; with proliferation of treatments for cancer of the prostate as well as for benign prostatic hypertrophy (BPH), the media is much involved with this gland.

Dr. Rous' update of his book, thus, is timely as well as truly informative. For the layperson, this book is an ideal source of information, covering just about everything that a nonspecialist would want to know. This book should be read selectively by those with a personal interest in one or more of the conditions described.

The book is clearly written, authoritative, and comprehensive, and this new edition certainly reflects current practice.

I must note, as a urologist, that the subtitle, "Sound Advice on Symptoms and Treatment," sounds like a bit of an inside joke. ☐ Robert Zufall, MD

SURGICAL ATTENDING ROUNDS

K. Francis Lee, MD, and Cornelius M. Dyke, MD. Philadelphia, PA, Lea & Febiger, 1992. This 400-page text, edited by two of the resident surgeons at the Medical College of Virginia in Richmond, Virginia, is an interesting venture. Each of the common surgical disorders is discussed in the context of a patient presentation as one might make on attending rounds, followed by a series of questions and answers concerning the condition. The editors suggest that medical students and residents learn about disease "a patient at a time" and suggest that this patient-focused text may better prepare students and residents about the topics discussed. The text is clear and well written and the diseases are discussed in some detail. I suspect that residents and medical students will find this a very useful adjunct to their regular reading from standard texts and probably will prepare them well for the kinds of questions they will encounter on attending hospital rounds. ☐
Benjamin F. Rush, Jr, MD



What Mom can remember is remarkable. What she's forgotten is heartbreaking.

As Alzheimer's Disease Progresses, it is not unusual for its victims to have clear memories of childhood, yet not recognize those dearest to them. It is this tragic symptom and others that make Alzheimer's as devastating to a victim's family as it is to the victim.

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In conjunction with consultants from the Dementia Research Clinic at the Johns Hopkins University School of Medicine, Meridian Healthcare has supported a series of studies aimed at innovating new and better ways of caring for the memory impaired.

Meridian's leadership role in supporting dementia research resulted in the first Alzheimer's care unit modeled on principles of modern psychiatry. Today that research is embodied in a program called Focus, now in place at Meridian Nursing Center–Westfield.

The goal of Focus is to prolong the independence of the memory impaired by sharpening their remaining abilities. Focus offers an individual program of care for each patient, provided by a specially trained staff in a secure and structured residential environment. For families struggling to cope with the consequences of their loved one's illness, Focus offers education, counseling and support.

If someone you love has Alzheimer's Disease, call and ask for our free Focus brochure. While there is no cure, Focus offers the care you and your loved one need.

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LETTERS AND VIEWPOINTS

MSNJ AND THE PRO

On behalf of The PRO of New Jersey, Inc., I would like to congratulate William E. Ryan, MD, on his ascent to the presidency of the Medical Society of New Jersey. Already, in his brief tenure, he demonstrates the qualities of sagacity and leadership that typify American Medical Association (AMA) standard bearers.

I refer with some exasperation to his gratuitous remarks in the June issue of *NEW JERSEY MEDICINE,* as part of his inaugural address. His reference to "stealth medicine" and unfair "Monday morning quarterback" decisions are perplexing. The AMA is on record as favoring peer review by local physicians. The definition of review is: "looking over again; retrospective view or survey, as of past events, experiences." In point of fact, current AMA President John Lee Clowe, MD, has stated recently, "We need to do all that we can to show that we can keep our own house clean—through peer review, the development of practice parameters, and self-regulation—because it is our only hope of preserving our professional autonomy." Is Dr. Ryan suggesting we perform prospective review of charts prior to the actual rendering of care?

Dr. Ryan may have forgotten that it was the AMA that acceded in 1965 to the request of the federal government to accept the Medicare program, thereby opening the door to federal intervention into the practice of medicine in this country. The government, as purchaser of health care, was entitled to examine the product.

Incidentally, Dr. Clowe's reference to practice parameters reminds one of the initial uproar regarding the guidelines used years ago by PSRO nurses as a screening tool in reviewing charts. These were loudly decried at that time as "cookbook medicine." Strangely, silence accompanies the AMA's promulgation of "practice parameters," which potentially are far more intrusive and restrictive to the practicing physician.

Finally, it is further disheartening to note that while the AMA, most state medical societies, the physician population in general, and federal and state legislators oppose self-referral, MSNJ is marching boldly in the opposite direction. Unfortunately, as this is written, the AMA has demonstrated its inconsistancy and lack of resolve by again modifying its position.

Nevertheless, I sincerely wish every success to Dr. Ryan. His intentions surely are laudable, though perhaps misguided. Lest you feel I am totally in disagreement with Dr. Ryan, be assured that I concur entirely with his statement, "yet our foes do increase every day." And I respectfully suggest, to paraphrase Pogo, "We have met the foe, and they are us." □ David I. Kingsley, MD, President, The PRO of New Jersey, Inc.

REPLY: MSNJ AND THE PRO

I thank David I. Kingsley, MD, president of The Peer Review Organization of New Jersey, Inc., for his letter congratulating me on ascending to the role of the presidency of the Medical Society of New Jersey.

Dr. Kingsley objects to a sentence in my inaugural address in which I state, "We are under daily surveillance by The Peer Review Organization of New Jersey, Inc., whose agents practice 'stealth' medicine, and make unfair 'Monday morning quarterback' decisions against responsible health care professionals."

I set forth the view held by a number of physicians that the PRO process, in many instances, is inappropriately and secretly performed to the detriment of the physician community. I have no problem with open and aboveboard review in which the apparent offender personally is notified of an adverse action of The PRO, so that the physician may dialogue the findings prior to the action. The local reviewer is supposed to do this but remains anonymous, rendering a sanction the physician then must appeal.

In my own experience, this has occurred three times with three successful overturns at the appeals level. In the first instance, an appeals reviewer backed off when it was obvious that as a nonrheumatologist he was unfamiliar with the drugs used to treat rheumatoid arthritis. In the second instance, I was cited for an 11-day gap between the time of admission and surgery on a patient. The reviewer missed the fact that there was an operation performed on day 4 that necessitated the second surgery. When this was pointed out, the issue was dropped. In the third instance, there was a complete misunderstanding of why the patient was admitted and even some question as to whether or not the reviewer had confused my patient with another patient. The PRO, after a hearing, sent a letter sustaining my position; this occurred only after many months of needless hassle in which the review records apparently were "lost." I did not need to go through these

experiences had the reviewer simply dialogued the issue with me at the outset. In no instance was I made aware of the fact that there was an issue until the hospital indicated that The PRO was involved. No physician contacted me.

Dr. Kingsley refers to the AMA positions on PRO. For his information, I have forwarded copies of 85 AMA policies on the PRO taken over the years and cumulating in the 1992 *AMA Policy Compendium.* These policies address due process and PRO review, notification of denials by the PRO, rights of appeal under the PRO, and qualifications of PRO reviewers.

To be specific, item 340.946, "Due Process and PROs," states, "It is the policy of the AMA to attempt to reverse the PRO practice of withholding the identities and credentials of the physician reviewers and to demand that any physician subject to PRO review be guaranteed the right to representation of legal counsel at all stages and be granted due process protections." Policy 340.978, "Monitoring PRO Activities" goes on to "encourage physicians to report their concerns with the PRO program, including problems with retrospective denials and sanctions, to the AMA PRO monitoring project and to state medical associations."

Dr. Clowe's remarks as expressed in the second paragraph of Dr. Kingsley's letter were misinterpreted. AMA policy is to work for the elimination of prospective review of the ten surgical procedures that had a denial rate of .58 percent, making PRO review cost ineffective.

The entire PRO process now is subject to considerable revamping under the new PRO fourth scope of work. Apparently this was felt necessary because of perceived deficiencies in the current PRO review process.

Finally, I call attention to a recent issue of *The Wall Street Journal,* which is critical of the concept that utilization review truly lowers medical cost. The article states, "While utilization review often does cut such costs for employers, the administrative burden it imposes on doctors and hospitals may actually be increasing rather than lowering the nation's total medical bill." In fact, the article quotes the study by Woolhandler and Himelstein writing in *The New England Journal of Medicine* indicating that "utilization review and similar programs have required an army of bureaucrats to eliminate modest amounts of unnecessary care."

I think a process founded upon review by highly qualified physicians and personal dialogue with their counterparts prior to any PRO sanction or other activity would be in the best interest of all. ☐ William E. Ryan, MD

NEW BUSINESS PRACTICE RULES

The willingness to present both sides of the important debate on the State Board of Medical Examiners' (SBME) new business practice rules is a tribute to *NEW JERSEY MEDICINE*'s value as a policy forum. Dr. Lewis's spirited rebuttal (pages 774-776) to the article by Mr. Kern (pages 469-471) is interesting.

First, Dr. Lewis, like Mr. Kern, regrettably casts the debate in terms of SBME members' motivations. Dr. Lewis notes, for instance, that the rules "were developed from issues raised by a prior state commissioner of health"—a reference to events that occurred seven years ago and perhaps are of interest to regulatory archivists. What Dr. Lewis really is saying is that SBME members were not, as Mr. Kern implied, simply promoting the economic interests of hospitals against the interests of physicians. To be sure, hospitals appear as upset as physicians about SBME's rules, so Mr. Kern's implication probably is misleading and is besides the point.

Second, the legal fine points in Dr. Lewis's rebuttal obscure most observers' central concerns about the rules: They are seen as vague, highly encompassing, and extreme in their interpretation of the Health Care Cost Reduction Act of 1991. The Act was extreme enough in its own right; of its two key features, the Health Care Trust Fund has been struck down in federal court as illegal, and the State Health Plan has been deprived of legal force by the Legislature. But, no one in 1991 read the Act as aggressively as SBME apparently read it, seeing it as authority for limiting physicians' right to refer patients even to community hospitals.

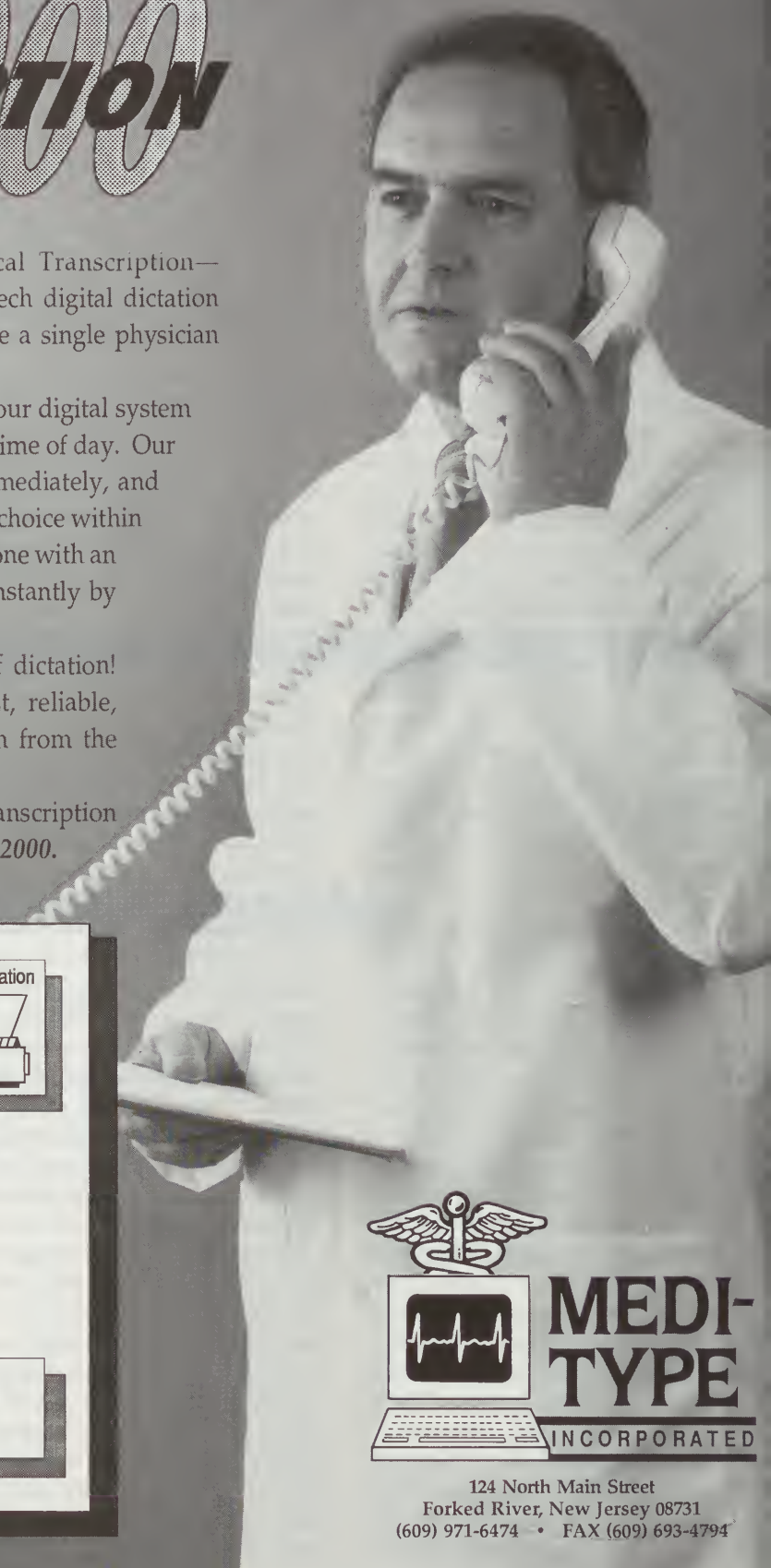
Finally, the rebuttal ignores the truly lamentable circumstances of the rules' adoption. After lying dormant for several months—following a hostile reception in the medical community—the rules suddenly rose phoenix-like at a SBME meeting with the rationale that they must be adopted immediately because otherwise the proposal to adopt them would "lapse." A weaker justification for sweeping, confusing, and ominous regulations is hard to imagine. Concerns expressed by the Medical Society of New Jersey (MSNJ) simply were ignored.

One hopes that SBME will follow through on a MSNJ suggestion to develop a question-and-answer guide that accurately reports what physicians may and may not do. Fair regulations allow people to predict accurately whether and when they will be found in violation.

As a former regulator, let me add that the most effective regulatory approaches emerge from reasoned discussion between the regulators and the regulated community—not from mutual confrontation. Accordingly, Dr. Lewis's contribution to the dialogue is a positive sign. ☐ Neil E. Weisfeld, JD, MSHyg, Director, Education, Research & Regulatory Affairs, MSNJ

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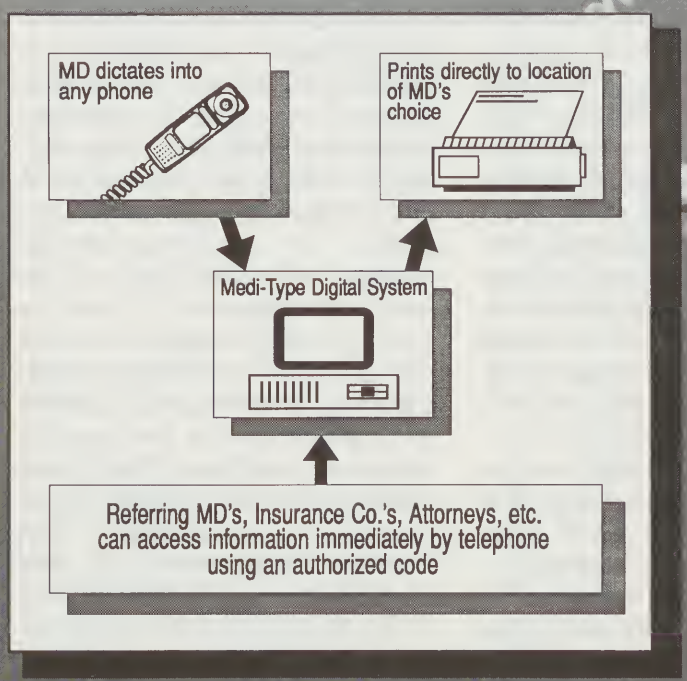


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GUEST EDITORIAL

NATIONAL MENTAL HEALTH MONTH

October is National Mental Health Month. The significance of the national recognition of the prevalence, importance, and impact of psychiatric disorders at home, in the family, and in the workplace should not be lost on the practicing physician. Over one-half of all initial patient contacts for mental health services originate with visits to physicians. This observation first was documented in a survey by the National Institute of Mental Health (NIMH) in 1978,[1] and still appears to be the case even in the current practice environment of regulation, HMOs, IPAs, and managed care. The practicing physician is the linchpin of the "de facto system" of mental health care in the United States. In our opinion, it behooves all physicians to be aware of this fact and to have an interest in and knowledge of psychiatric disorders, treatment, and referral patterns for their patients who present with such problems.

In a similar vein, data from another NIMH study, the Epidemiologic Catchment Area (ECA) survey, present high prevalence figures for psychiatric disorders in a variety of settings.[2] This community survey gives such lifetime prevalence figures as 14.6 percent for anxiety disorders, 8.3 percent for affective disorders, 1.7 percent for organic brain disorders, cognitive impairment (severe), and 1.5 percent for schizophrenia/schizophreniform disorders. These figures have obvious implications for practicing physicians, recognizing that the majority of troubled individuals first will go to their physicians for help with their problems, and then may be referred to another part of the "mental health care system" for treatment.

In addition, in the area of the interface between psychiatry and medicine, the practical importance of this interface goes beyond the notion that primary care physicians are "gatekeepers" for the identification and referral of patients with psychiatric disorders. A host of general medical disorders frequently presents to primary care physicians with behavioral, psychiatric, and/or cognitive symptoms: these disorders, thereby, are susceptible to being misdiagnosed as primary psychiatric disorders. These include HIV infection, a protean "great deceiver" (like syphilis); subdural hematomas; normal pressure hydrocephalus; multiple sclerosis and other demyelinating disorders; seizures; parkinsonism; systemic lupus erythematosus; hyper- and hyponatremia; and B-vitamin deficiencies.[3] Impotence is a classic early complaint of men with diabetes; depression is a classic presenting complaint of women with diabetes or hypothyroidism. A perusal of the pharmacologic literature, beginning with *Physicians' Desk Reference,* underscores the critical relevance of psychiatry to primary care physicians, since a host of commonly prescribed medications have important behavioral side effects. A classic paradigm is depression caused by alpha-methyldopa (Aldomet®); some primary care physicians may not know that propranolol (Inderal®) also can be a potent and common cause of depression that can reach suicidal proportions. Primary care physicians also may not be aware that the commonly prescribed tricyclic antidepressants may trigger frank manic episodes in individuals with an underlying bipolar (manic-depressive) disorder. Similarly, the distinction between symptoms that are truly "medical" versus those that also are "psychiatric" is an area that requires collaboration among medical specialists. A classic example is the "pseudodementia" of the aged, which often requires treatment with antidepressants. Conversely, many elderly individuals have treatable dementias that are not caused by depression, and that require ongoing care by neurologists, endocrinologists, and—in the case of normal pressure hydrocephalus—by neurosurgeons. Finally, in the area of panic and anxiety disorders, the differential diagnosis of such medical signs and symptoms as chest pain, shortness of breath and hyperventilation, weakness, dizziness, and many others should include panic/anxiety disorders. These disorders can and often do present with cardiovascular, gastrointestinal, neurologic, and other such "organic" symptomatology.[4]

In early 1993, *NEW JERSEY MEDICINE* will present a special issue on psychiatry. This issue will address a variety of issues, problems, and solutions in mental health care encountered by practicing physicians. In addition, several recent articles and editorials in this journal have addressed such diverse psychiatric, ethical, and related medicolegal issues as depression, psychopharmacology, and advanced directives in health care. All of these efforts are in recognition of the impact and importance of psychiatric disorders in general, and of the central role of the practicing physician in addressing these disorders.

We endorse and support Na-

tional Mental Health Month. By placing mental health in the public eye and by raising public awareness to these issues, mental health associations, societies, and other groups that sponsor National Mental Health Month are performing a valuable service to the general community. And by presenting practical and useful information and material to the readership of *NEW JERSEY MEDICINE*, we hope that we are "doing our part" for the medical community. ☐ Daniel P. Greenfield, MD, MPH, MS; Jeffrey A. Brown, MD, JD, MPH; and David Miller, MD

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Dr. Greenfield is a member of the Editorial Board of *NEW JERSEY MEDICINE;* a managing partner with Brown and Greenfield Physician Consultants; and affiliated with the Department of Psychiatry, Albert Einstein College of Medicine/Montefiore Medical Center, New York. Dr. Brown is a managing partner with Brown and Greenfield Physician Consultants and is an attending, Saint Barnabas Medical Center and Elizabeth General Medical Center. Dr. Miller is director, Summit Psychiatric Counselling Associates and the Cognitive Therapy Center, Summit. Address reprint requests to Dr. Greenfield, 256 Columbia Turnpike, Suite 210, Florham Park, NJ 07932.



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GUEST EDITORIAL

THE IMPORTANCE OF CANCER REGISTRIES

Eradication of cancer is an elusive goal, owing to the biologic complexities and the diagnostic challenges it presents to clinicians and researchers.

"Cancer control" is a term encompassing all of the public health efforts—prevention, surveillance, early detection, and treatment—intended to address the issue and, ultimately, to approach the achievement of this goal. This process requires a multifactorial approach utilizing, in part, epidemiologic techniques to gain relevant information on incidence, risk factors, natural history, and survival.

Cancer registries have proved to be a vital part of the overall cancer control effort and have been shown to be of immense value in analyzing occurrence and trends and of great utility in helping to focus programs and monitor progress.

The value of New Jersey's cancer registry is highlighted in Dr. Kraut's article on pages 772-773.[1] The authors, representing the New Jersey State Department of Health (NJDOH), find the state's cancer registry a valuable tool in analyzing the occurrence of an unusual cancer "cluster" observed at the Meadowlands Sports Complex that was shown, most likely, to have occurred by chance.

Contrast this experience with an earlier study conducted by NJDOH in 1980. In this study, addressing an apparent cluster of leukemia and Hodgkin's disease cases that occurred in Rutherford, no conclusion could be drawn as to whether this was a chance event or possibly related to environmental factors, primarily because of a lack of a functioning tumor registry to assure adequate accounting of all incident cases.[2]

Cancer registries are an integral component of the overall cancer control effort. The National Cancer Institute recognizes their importance and has encouraged their establishment at national and state levels.

Important within this effort is the network of regional, local, and individual hospital registries that acquire information on every newly diagnosed cancer in a defined geographical area during a specific time period. Essential to this process is the tracking of incidence and mortality. Information derived in this fashion can be used to establish survival patterns and to refine screening and treatment practices.[3]

Other states have found the process invaluable as well. In Pennsylvania, the cancer registry was used to identify first-degree relatives of breast cancer patients and to promote increased risk awareness and more effective screening behaviors in that population.[4] In New York, a cancer registry effectively identified cases and validated a mass screening program for colorectal cancer.[5] Also, registries recording family history data were shown to have great potential for recognition and prevention of hereditary and familial cancer.[6]

Important linkages between cancer registry services and state health departments have been shown, as well, to potentiate effective cancer control programs.[7]

Currently, there are cancer registries in 38 states.

Such programs are costly and expansion of them in a time of shrinking health care dollars is problematical. Federal legislation introduced by Representative Bernard Sanders (D, VT) and Senator Patrick Leahy (D, VT) (HR4206/S2205) proposes to appropriate $30 million per year to establish and/or support cancer registries in every state and create a national database to track cancer statistics. New Jersey would be eligible to receive funding under this legislation to study elevated breast cancer mortality rates occurring in this state. Passage of such legislation could have far-reaching implications in the "war on cancer."

Cancer registries have come of age. Far from being dormant repositories of uninspiring data, they are vital, active agencies in the overall cancer control effort. ■ Alan J. Lippman, MD

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EDITOR'S DESK

DISCOVERY DAY

Behind him lay the gray Azores,
Behind, the Gates of Hercules;
Before him not the ghost of shores;
Before him only shoreless seas.
The good mate said: "Now must
we pray,
For lo! the very stars are gone.
Brave Admiral speak; what shall
I say?"
"Why, say, 'Sail on! Sail on!' and
on!"
Joaquin Miller, *Columbus, 1896*



Howard D. Slobodien, MD

We would be remiss if we were to allow this October to pass without noting the 500th anniversary of the first of the four voyages of Christopher Columbus to the New World, even though the Americas were not named for him.

Many celebrations have been planned. Spain, as might be expected, leads the list and intends to spend hundreds of millions of dollars on its events, including a World's Fair in Seville. This World's Fair will be hard pressed to emulate the glitter, panache, and success of the World's Columbian Exposition, dedicated 100 years ago in Chicago. The Chicago fair was notable on several accounts. The facade of its buildings incorporated a plaster base that lent it the appellation "White City." Its use of electricity for lighting and technology set new standards of extravagance. Its super-attraction was a gigantic iron wheel, built by George Ferris and capable of carrying more than 2,000 people to a height of 275 feet. And it was the first fair of its kind in the United States to show a profit, despite admission fees of 50 cents.

Replicas of the three ships that made the first voyage in 1492 were constructed by Spain, reenacted that original itinerary, and participated in the parade of the tall ships in New York harbor on July 4, 1992. We were privileged to inspect the Ohio version of the *Santa Maria* on the Scioto River in Columbus earlier this year. It is somewhat frightening and awe inspiring to realize the daring and courage of those who sailed these tiny vessels into uncharted waters.

The three small ships and most of their crews originated and sailed from Palos de la Frontera, a small coastal town. The flagship, originally known as *La Gallega* and renamed *Santa Maria* by Columbus, was a three-masted square-rigged nao, an ordinary slow cargo ship of 202 tons with a length of 77 feet. The *Pinta,* a three-masted caravel, was 70 feet in length. And the *Santa Clara,* the favorite of Columbus and called, affectionately, the *Niña,* was a four-masted caravel, also 70 feet long. Many of us would hesitate to sail in New York Harbor or in Chesapeake Bay in ships of such miniscule dimensions. Fortunately for the crew of the small fleet, Columbus probably was the premier sailor and the best dead-reckoning navigator of his time.

The year 1492 was a red-letter one in the history of Spain. As Columbus noted in his log, the early months of that year saw the ousting of the Moors and the placing of the banners of Isabella and Ferdinand on the towers of the Alhambra. He also noted the simultaneous banishment of the Jews from Spain, a note somewhat ironic because Simon Wiesenthal and others have produced considerable evidence that Columbus had a partial Jewish inheritance, although he always acted and testified as a devout Christian. (The idiotic movie, *Christopher Columbus: The Discovery,* released this past summer, trades on the heritage in a somewhat apocryphal scene between Columbus and a Jewish cabin boy.)

The journey was designed to visit Asia, especially the East Indies, after a stop at the Canary Islands, in order to see the Great Khan and his people and to attempt their "conversion to our Holy Faith." Columbus remained convinced to the end of his life that he indeed had reached Asia. The maritime maps of the day indicated this; the Viking voyages were considered to have occurred in Asia and the idea that a new land had been discovered did not enjoy widespread acceptance until the middle or late 1500s. Regardless of designation, landfall was made. To quote from the log of October 11, 1492:

> "The moon, in the 3rd quarter, rose in the east shortly before midnight. I estimate that we were making about 9 knots and had gone some 67½ miles be-

tween the beginning of night and 2 o'clock in the morning. Then, at two hours after midnight, the *Pinta* fired a cannon, my prearranged signal for the sighting of land."

Thus, the land, called San Salvador, was sighted in the early hours of October 12 and received the royal banners and the "protection" of the Spanish monarchs later that day. Although Columbus (or Discovery) Day is officially listed as October 12, the original date was entered under the Julian Calendar; under today's Gregorian Calendar the date should be entered as October 21. But, ever since we discovered the value of three-day weekends, the true date probably is of less consequence; we celebrate on a Monday, regardless of numbers.

The first voyage was one of discovery and reconnaissance. Later voyages, by Columbus and other explorers, were trading expeditions. The Old World received gold, tobacco, dye stuffs, corn, potatoes, chilis, and chocolate. The New World received coffee, wheat, rice, livestock, and, shamefully, slaves from Africa. This may be the reason why some in Spanish America suggest that 1992 be a year of mourning there and in the Caribbean, calling October 12, 1492, the "beginning of one of the greatest acts of genocide, pillage, and plunder in human history." Cuba has been expected to show opposition to the Spanish conquest, but its presence at the Olympic Games in Barcelona was punctuated only by the performance of its athletes.

Despite these objections, the Spanish government has mounted a four-year campaign to have Americans reflect on the voyages of Columbus as a way of strengthening relationships between the two countries. And the Dominican Republic, whose capital was the first Spanish colonial city in the New World and where some of Columbus' remains remain, has planned a blockbuster fete. The greatest explorers seem to have found something other than for what they were looking. Perhaps, in 1992, we shall derive more from the quincentenary observances than we expected.

Hasta luego. □ Howard D. Slobodien, MD

What is food to one man may be fierce poison to others.

Lucretius (95-55 B.C.)
De Rerum Natura

One man's poison ivy is another man's spinach.

George Ade
Hand-Made Fables (1920)

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Rousseau
The Social Contract (1762)

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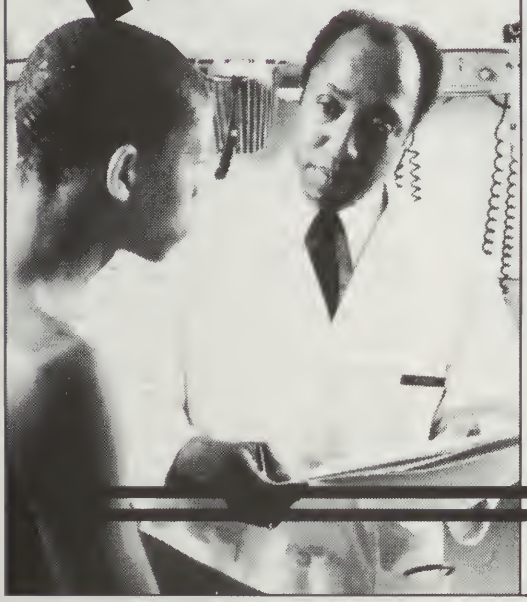
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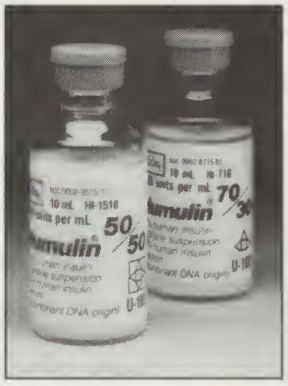
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PRESIDENT 'S PAGE

UNCOMPENSATED CARE TRUST FUND

Much is at stake for physicians in New Jersey as legislation develops for the replacement of the collapsed Uncompensated Care Trust Fund (UCTF). The issue is our ability to continue to care for patients formerly in UCTF, to secure physician reimbursement for this service, and to avoid an oppressive provider tax.

On May 27, 1992, United States District Court Judge Alfred Wolin held that self-funded, pension-protected health insurance plans (ERISA) are exempt from paying state-mandated surcharges added to hospital bills. The governor and the legislators were mandated to work together to secure a funding alternative. The issue has been remanded to the third circuit court of appeals in Philadelphia. A plan to be drafted by the Legislature is expected to secure administrative approval by November 30, 1992.

In the interim, interested parties have been developing their positions. In the absence of any constituted legislative committee, MSNJ has been a member of the Coalition for Health Care Reform. This 15-member committee, representing providers, business and industry, labor, and other groups, has been discussing issues related to replacing the collapsed UCTF. MSNJ representatives have been present at virtually every meeting.

The problem is $800 million must be found, assuming that UCTF obligations will be met again, and Judge Wolin's decision will disallow hospital reimbursements for Medicare, Medicaid, and Blue Cross shortfalls and differentials. The total revenue shortfall is $1.5 billion.

The patients being serviced in UCTF are a heterogeneous group. They include charity care,



William E. Ryan, MD

working poor, and individuals with significant means who do not choose to purchase insurance. Of the 843,000 recipients of care from UCTF, one-fourth are truly indigent.

The issue becomes larger than first perceived. Hospitals that formerly received full-amount DRG reimbursements for patients including makeups for shortfalls now are at catastrophic risk. This is true of inner-city facilities. No one is rushing to pick up the tab. In addition, physicians who formerly had given as much as $500 million in free services per year to the indigent are not in a position to do so. A position paper of the New Jersey Hospital Association of April 10, 1991, stated, "Physician calls for indigent care reimbursement equity were further frustrated because physician compensation for services to the poor has been neglected in the Uncompensated Care Trust Fund legislation. In the past, physicians believed that a system that disregards their grievance is inequitable. . . . Medical staff physicians who are not employees of the hospital have not been compensated for the care of indigent hospital patients. Obviously, an inequity in the distribution of the burden between hospitals and physicians is apparent." I believe this inequity must be corrected. The time to do it is now.

I have asked John Capelli, MD, of the Council on Legislation and fellow members of the Council to develop a position paper. Dr. Capelli has produced an excellent document addressing our concerns. This document needs consideration by the MSNJ Executive Committee, whose members are drafting a position within a short time frame.

Dr. Capelli's paper is devoted to developing a new funding mechanism and source for uncompensated care, consistent with the federal court ruling and to indemnify and implement specific cost reductions that will curtail the uncontrolled cost of medical care, reduce the cost of administration, and generate new funding sources.

Dr. Capelli suggested MSNJ support the concept of providing full funding for the truly needy patient, but patients with some resources receive health care through the purchase of insurance or other funding mechanism. Whether employer mandated or not, a basic plan similar to the "AMA minimum benefit package" should be offered.

The complex and administratively overburdensome DRG should be done away with or streamlined so the charge system closely reflects the cost of care. MSNJ feels that hospital rates should be driven primarily by an institution's specific cost for care, allowing the charge for the cost of care to be driven by

marketplace and insurer forces. These should be part of usual business practice and should not be a component of uncompensated care funding source.

Legislative initiatives include expanding Medicaid eligibility to 200 percent of the federal poverty line and making it more efficient and hassle free. Medicaid fees should be set at 85 percent of the Medicare fee schedule with a phase in to full Medicare schedule in five years.

With the removal of bad debts, the expansion of Medicaid, and the availability of affordable basic health care policy, the number of truly needy whose health care is the purview of government funding should be greatly reduced.

Debate continues on whether a specific source of revenue funding should be advanced to the Legislature. Some feel this should be left to the legislators. Others feel that taking up the unions and business and industry on their advancement of a payroll tax is not a bad idea. However, in this election year, payroll taxes would be anathema. After the election and before November 30 would be the appropriate time to debate such a tax. "Sin" and gasoline taxes are alternatives.

What we wish to avoid is the provider tax that was legislated in Minnesota. This 2 percent gross income tax results in a 6 percent tax on net income that physicians in Minnesota find onerous. Institutions feel similarly disturbed.

Dr. Capelli's plan includes considerations for a regulatory reform review panel, pharmaceutical cost control, PRO review, and major malpractice reform. Business and industry feel that defensive medicine costs would be reduced by malpractice reform. Trial lawyers and the Legislature would have a different view.

What will happen between now and November 30 is anyone's guess. My hope is that MSNJ, through its representatives and physician input, will be able to sway the Coalition and the legislators and make them realize our views are just and realistic. We are asking for consideration for physician reimbursement under this fund that physicians have not previously enjoyed. In this economic climate, legislators will not be especially supportive. Please play an active role. ☐ William E. Ryan, MD

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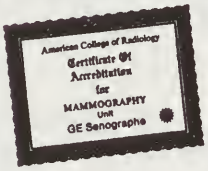
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Review Article: Venous Thromboembolism in Trauma Patients

Christina G. Rehm, MD
Richard K. Spence, MD
Steven E. Ross, MD

The increased coagulability in multiple injured patients results in increased risk for deep venous thrombosis and pulmonary embolism. The authors discuss etiology, diagnosis, treatment, and prophylaxis of venous thromboembolism in trauma patients.

Changes in the coagulation system form part of the physiologic response to injury. The overall result is an initial increased coagulability, a response that improves homeostasis, but increases the risk for development of deep vein thrombosis. The incidence of deep venous thrombosis in trauma victims has been reported to be between 10 to 100 percent depending on the patient population and method of diagnosis.[1-3] The most critical periods are the immediate post-trauma period, and the first two weeks following injury.[4] This intrinsic risk associated with injury is compounded by a long list of additional risk factors (Table).

At great risk for later embolic phenomena are patients with spine fractures, pelvic fractures, and lower extremity fractures, in whom orthopedic manipulations are delayed, which may lead to mobilization of previously formed clots with pulmonary embolization.

Other important risks are deep vein thrombosis of the upper extremities, associated with central venous lines. Such clots have been reported to occur in as high as 30 percent; 12 percent of the clots resulted in pulmonary emboli. Circumferential size of the catheter, thrombogenicity of the catheter material, and composition of infusate (including pH and osmolality) have all been implicated in the formation of these clots.[5]

Unfortunately, only 35 to 50 percent of patients who develop pulmonary embolism will have clinically symptomatic deep venous thrombosis. Only an aggressive approach to diagnosis and high degree of suspicion for both deep venous thrombosis and pulmonary embolism coupled with systematic prophylaxis for all patients at risk can prevent these complications.

DIAGNOSIS

The vascular laboratory diagnosis of deep venous thrombosis relies on functional and/or anatomic assessment of the deep venous system. Plethysmography—either volume, strain gauge, or impedance—fits into the category of functional, noninvasive testing. A test is positive in the leg when there is an increase in maximal venous outflow (MVO). This occurs when an occlusive thrombus is situated in the popliteal vein or above. In addition, extensive clotting of calf and thigh veins can lead to a decrease in segmental venous capacitance (SVC), i.e. the amount of blood filling the leg veins in a pre-set time period. The combination of a prolonged MVO and a decreased SVC make a plethysmographic diagnosis of proximal deep venous thrombosis.

Plethysmographic tests have some limitations. Because the tests are indirect measures that do not visualize veins, they have decreased sensitivity compared to phlebography. The tests cannot detect calf vein or nonocclusive thrombi reliably. Although impedance plethysmographies (IPGs) can provide some suspicion of a risk of pulmonary embolism in the ambulatory patient, we have found them unreliable in the critically injured.[6] Furthermore, extrinsic venous compression can produce false positive IPGs, e.g. with hematomas in the retroperitoneum adjacent to the vena cava, perirenal collections, or extensive liver packing. Ventilated patients on high levels of positive end expiratory pressure or with significant chest injuries may show interference with venous outflow caused by abnormal chest cavity dynamics, making plethysmography difficult to interpret. Trauma patients frequently have lower extremity injuries. The inflation of compression cuffs required for plethysmographic studies in these circumstances is uncomfortable, if not impossible. Test results in

moving, uncooperative patients are worthless. We do not recommend the use of plethysmography in trauma patients as a sole means of diagnosis. False negative and false positive studies can lead to disaster; in the former, a fatal undetected pulmonary embolism; in the latter, complications from unnecessary surgery or anticoagulation.

Extensive experience has been gained using iodine 125-labeled fibrinogen scanning to detect the appearance of new deep vein thrombosis in the perioperative period. This is a highly sensitive test that depends on the conversion of fibrinogen into fibrin as new clot is formed. Positive scans of the leg performed 24 to 48 hours following administration of the radio label will demonstrate isolated areas of uptake in the leg veins. Because of its dynamic nature, this is the only testing modality that can distinguish a new clot from an old clot. It has not been used in multiple trauma because of its low specificity. In 1990, the manufacturer removed the product from the clinical market.

We prefer duplex scanning for diagnosing deep venous thrombosis in the trauma patient because of its high sensitivity and specificity. It relies on both ultrasonic visualization of the deep veins and Doppler analysis of flow, combining both anatomic and functional measures. Ultrasound criteria include direct visualization of clot in the suspect vein and indirect evidence of thrombosis in the absence of wall motion with pressure from the probe. Lack of compressibility seen with ultrasound can be corrobated by the use of Doppler flow analysis during compression maneuvers such as inspiration Valsalva maneuver, or manual compression of the distal thigh or calf.

Duplex diagnosis of deep vein thrombosis has been compared favorably to the gold standard, phlebography.[7] Its significant benefit is that it can be performed at the bedside, and can be repeated as often as needed without risk, but it is dependent upon a skilled technician for real-time interpretation. The presence of external fixation devices on the lower leg may hinder performance of the test. It cannot distinguish a new clot from an old clot. Nevertheless, in our opinion Duplex scanning is the best available test for deep vein thrombosis in the trauma patient.

Phlebography has been the gold standard for diagnosing deep venous thrombosis because it is a direct, anatomic, and morphologic test.[8] The study is performed in the radiology suite and requires injection of a contrast agent directly into the veins of the foot. Tourniquets are used to direct the flow of contrast into proximal veins. A directly positive test outlines thrombus in a vein with dye. Absence of filling of a vein is used as an indirect indication of deep venous thrombosis. The proximal femoral vein is the most difficult segment to fill and, therefore, to assess accurately. Flow artefacts in tibial veins may be mistaken for a clot. In the traumatized limb, this finding can be caused by external compression or may demonstrate a vein that is occluded secondary to the initial injury or surgical ligation, not a new deep venous thrombosis. Any decision to institute treatment for deep venous thrombosis based on phlebograms should be done with the best knowledge of the patient's initial injury to avoid unnecessary anticoagulation.

Phlebography carries risks. Phlebography has been reported to be associated with thrombophlebitis in up to 50 percent and even the occurrence of pulmonary embolism during venography has been described.[9,10] Allergic reactions to the iodinated dyes are not uncommon. They may produce acute renal failure, especially if given to a patient with pre-existing renal damage, myoglobinuria, or volume depletion. Nonionic dyes lessen this risk but they are expensive and not always available. Bilateral testing usually is not done because of the need for a separate injection site and increased dye load. We have found phlebography to be most useful in situations where Duplex scanning is not possible, where information gained from noninvasive testing is in doubt, or when anatomic visualization of veins is required as a guide to surgery.

The two methods available for diagnosing pulmonary embolism in the trauma patient are ventilation-perfusion scanning and pulmonary arteriography. Ventilation-perfusion scanning is not reliable for intubated patients because of the difficulty in delivering the inhaled isotope. In addition, the accuracy of this test depends heavily on the interpretation of chest x-ray findings.[11] Lobar pneumonia or consolidation secondary to injury can easily mask a pulmonary embolus leading to a false negative reading.

We rely primarily upon angiography to make the diagnosis of pulmonary embolism; only small amounts of dye are needed. Our experience has been that there are few false negatives with angiography.

TREATMENT

The objective of treatment of venous thrombosis is to prevent the development of acute and chronic venous stasis complex or pulmonary embolism and/or pulmonary hypertension. There are two basic therapeutic methods: anticoagulation and venous interruption. Anticoagulation should be the primary choice. In the trauma patient, the most common contraindications are recent head injuries with intracranial bleeds and acute spinal cord injuries. Anticoagulation is not permanent, protects from embolization from all sources, not just from the lower extremity venous system, and does not require an invasive procedure.

Heparin most commonly is used to begin anticoagulation. Its

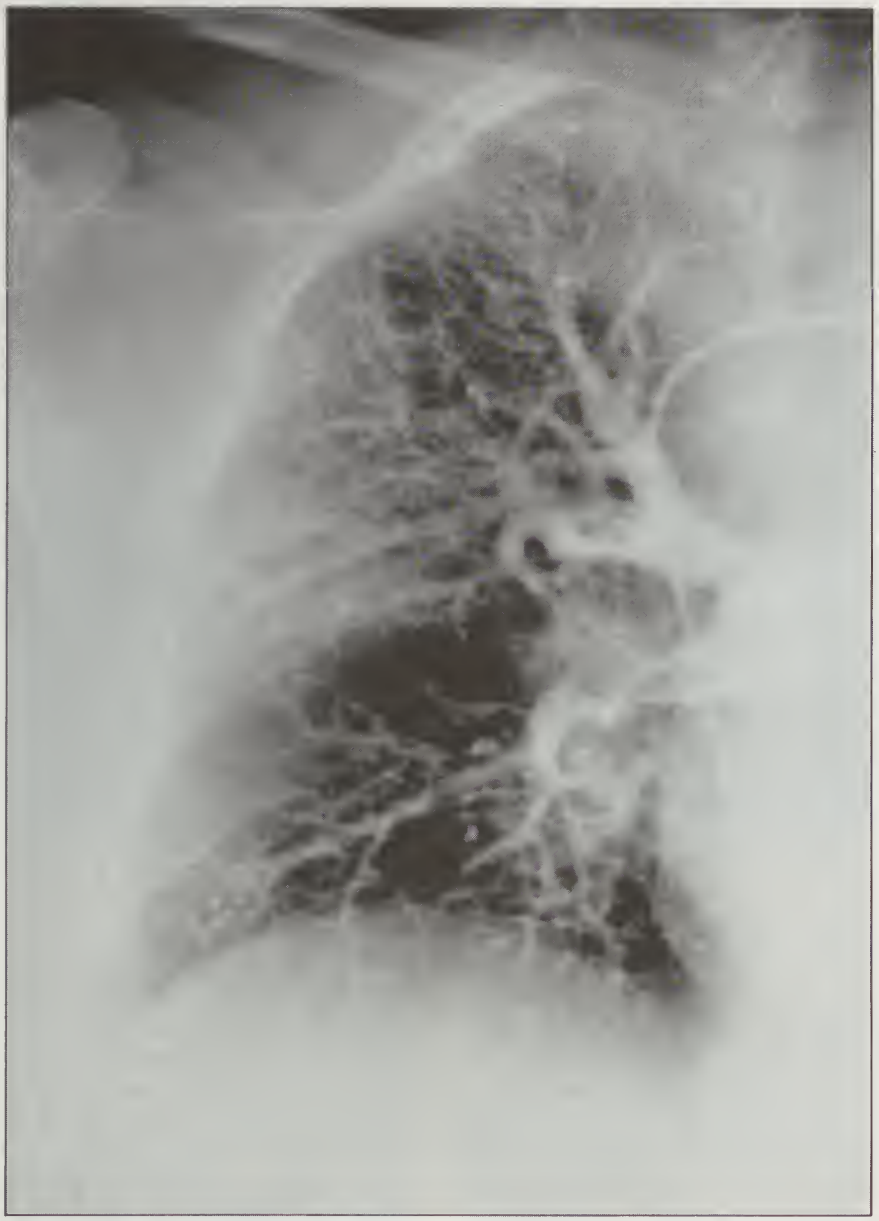


Figure 1. Major pulmonary embolus right inferior pulmonary artery.

effect is immediate. Continuous intravenous administration of heparin is the safest and most efficacious method.[12] Intermittent bolus dosing produces peaks and valleys of anticoagulation resulting in an increased risk of complications. Adequacy of anticoagulation is monitored by the partial thromboplastin time. The optimum range is 1.5 to 2 times control values. Those provide the least risk of recurrences and of bleeding complications. In this range recurrent pulmonary embolism will occur in less than 2 percent of patients.[13] Bleeding is the most common complication of heparin therapy occurring anywhere from 8 to 35 percent of therapeutically anticoagulated patients. Our own experience confirms a significant rate of unexpected bleeding, including intracranial, retroperitoneal, and gastrointestinal sites. There seems to be an increased risk in the elderly. Another dangerous risk is the development of thrombocytopenia, reported with an incidence, as high as 30 percent.[13] It is independent from dose or duration of therapy and may be associated with arterial thrombosis. It has been reported more commonly with bovine than with porcine heparin. The mechanism responsible remains uncertain, and patients with a history of this phenomenon, when rechallenged with heparin, may not experience recurrent thrombocytopenia. As symptoms range from nil to severe bleeding, platelet counts need to be monitored during heparin therapy, and all heparin including the minute amounts in intravenous flushes and monitoring solutions must be discontinued if thrombocytopenia occurs.

The reported complications of long-term heparin therapy, such as hair loss, osteoporosis, and pathologic fractures[14] are virtually unknown today, as long-term heparin anticoagulation is not used.

Sodium warfarin, given orally, inhibits vitamin K dependent coagulation factors and requires several days of therapy before becoming effective. It is initiated prior to discontinuing heparin therapy. Heparin is continued until therapeutic doses of warfarin are achieved. Therapy is monitored by measuring the prothrombin time. Therapeutic ranges for prothrombin time are 1.25 to 1.5 times control. The major risk with this drug is bleeding, especially as many drugs, food items, and underlying conditions will potentiate oral anticoagulants or interfere with their effect.[15] Prothrombin time needs to be tightly controlled, especially when warfarin is continued on an outpatient basis. Lack of patient compliance is a relative contraindication to this mode of therapy.[16]

An unusual complication is a warfarin-associated vascular purpura, manifested by skin necrosis. This usually manifests in the first weeks of therapy.[16] Warfarin also is contraindicated in pregnancy, because of teratogenicity, whereas heparin is safe during pregnancy.

Controversy exists about the length of anticoagulation.[3,16] Anticoagulation generally is recommended as long as risks for deep venous thrombosis or factors promoting venous stasis persist.[3,16] We agree with full dose anticoagulation for three months

Table. ***Risk Factors.***

Prolonged immobilization greater than three days; quadriplegia/ paraplegia
Age greater than 45 years
Previous history of venous thromboembolism
Head injury
Spine fracture without neurologic deficit
Pelvic fracture
Lower extremity fracture
Lower extremity venous repair
Lower extremity complex wound
Central lines

in patients without ongoing risk factors.[16] We recommend close outpatient followup and intense patient education.

Interruption of the inferior vena cava is reserved traditionally for two classes of patients—those with documented pulmonary embolus who have had recurrent embolus while anticoagulated, or those with pulmonary embolism and contraindication to anticoagulation. Trauma patients frequently fall into the latter category. In addition, prophylactic insertion of a caval filter has been advocated in some populations of trauma patients. Most often considered for a prophylactic filter are patients with spinal cord injuries, who may have a 100 percent incidence of deep venous thrombosis. These patients are at high risk of developing pulmonary embolism. Standard prophylaxis against deep vein thrombosis has not provided satisfactory protection.

We prefer to use the Greenfield filter because of its proved track record.[17] The rate of recurrent pulmonary embolus with a Greenfield filter has been reported as high as 4 percent.[18] The Greenfield filter's cone-shaped design prevents vena cava thrombosis. Clots are trapped and held centrally where they are lysed, allowing peripheral blood flow to continue. Inadvertent placement of the filter above the renal veins or in the common iliac veins is tolerated quite well.[19] Filters can be placed above the renal veins where the cava is clotted below and is the source of uncontrolled embolism. If a filter is placed incorrectly in an iliac vein, a second filter should be placed in the inferior vena cava to afford proper protection. The Greenfield filter is made so that the barbs that hold it in place pierce the walls of the vena cava. Clinically significant bleeding at the implant site rarely occurs. Filters have been known to migrate, and have been found in the superior vena cava and the right atrium.[19] Although the filter can be recovered from these locations, some have been left in place without immediate ill effects.[20] Filters are inserted through the right internal jugular vein or common femoral vein. Insertion should not be attempted through the left internal jugular vein because the filter introducer cannot negotiate the turn into the superior vena cava. Newer insertion devices for the Greenfield filter are 12 French in size, permitting safe percutaneous insertion with a dilator system.

Whenever the femoral vein is instrumented with infusion catheters or insertion devices, the risk of thrombosis is increased.

PULMONARY EMBOLISM

Pulmonary embolism is the most feared and dangerous complication of venous thrombosis, with mortality rates reported from 1 to 4 percent[7] and an incidence from 4 to 22 percent in the trauma patient. On the other hand, phlebitis occurs only in 35 to 50 percent of patients with pulmonary embolism, which stresses the importance of silent deep vein thrombosis.

Our own experience has confirmed that clinical symptomatology is unreliable. An aggressive approach to evaluate any respiratory compromise, not explained by abnormal chest x-ray findings, is necessary. We monitor all critically ill trauma patients with continuous pulse oximetry. Evaluation of all sudden unexplained prolonged desaturations that are unresponsive to pulmonary toilet maneuvers is necessary. We advocate arteriography exclusively for the diagnosis of pulmonary embolus in the multiple trauma patient, because it is the most accurate and reliable method. This is of utmost importance, because pulmonary embolus requires rapid institution of treatment—yet treatment modalities can be associated with serious complications. In the trauma patient, anticoagulation should not begin without unequivocal documentation of a pulmonary embolism.

Acute iliofemoral vein thrombosis carries a high risk of pulmonary embolism and significant long-term morbidity. If the outflow occlusion is severe enough, phlegmasia cerulea dolens can occur, leading to occlusion of distal arterial flow and venous gangrene. Treatment depends upon early recognition and differentiation from acute arterial occlusion or traumatic compartment syndrome. Acute arterial occlusion or traumatic compartment syndrome usually appear as an initial injury or within the first few hours after presentation, as opposed to phlegmasia, which occurs later in the hospital course.

Trauma patients rarely are candidates for lytic therapy because of recent injuries. Streptokinase and urokinase can lyse the offending clot, but they also lyse clots in other areas, making them too risky for use in this population. Standard treatment for this condition consists of elevation of the leg to reduce edema and anticoagulation. The latter also may be contraindicated. The only approach left is direct surgical clot removal, which is performed through a groin incision. The physician inserts a Greenfield filter prior to thrombectomy, if necessary through the internal jugular vein, to prevent intraoperative pulmonary em-

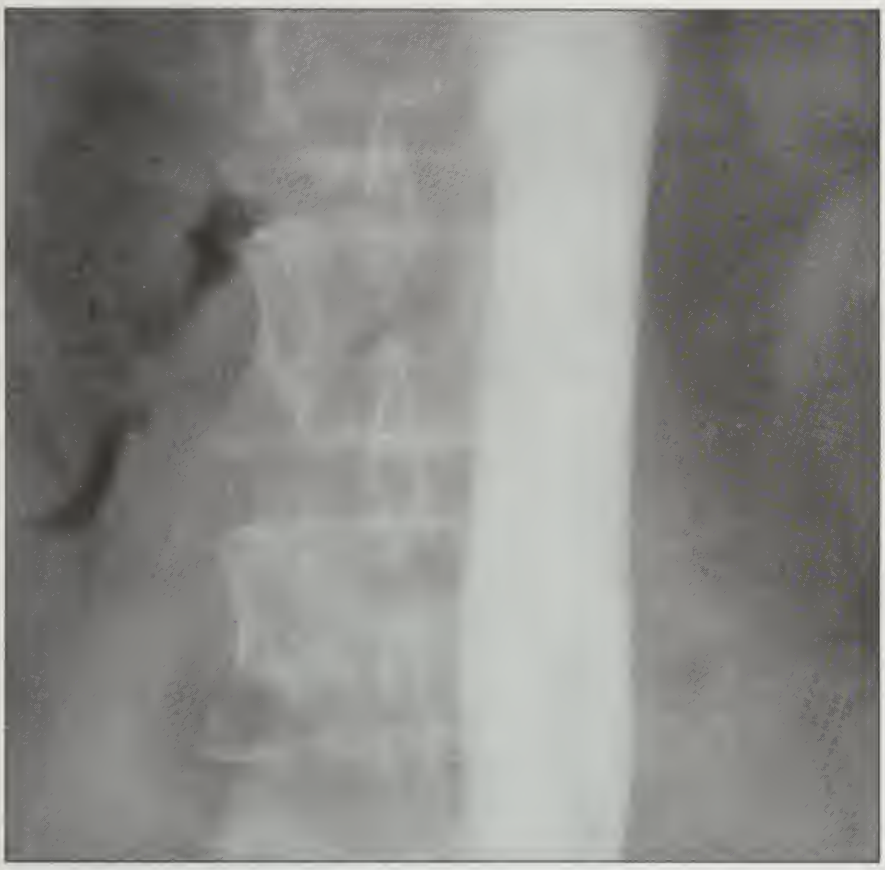


Figure 2. Visible clot inferior vena cava.

bolism. The distal veins are emptied by wrapping the leg with an Esmarch or rubber tourniquet bandage until all clot is removed. This operation is extremely bloody, so autotransfusion is advisable.

DEEP VENOUS THROMBOSIS PROPHYLAXIS

Prophylaxis is the "attempt" to protect the trauma patient from the development of thromboembolic phenomena. The incidence of deep venous thrombosis has very wide variation depending on the patient population and the method of diagnosis. The reported incidence of pulmonary embolism similarly varies widely.

None of the available methods of prophylaxis work for all subsets of patients. Treatment modalities for deep venous thrombosis/pulmonary embolism, i.e. full heparinization or placement of a vena caval filter, have been recommended as prophylaxis in some populations. Several methods are accepted for surgical or orthopedic patients. None of the methods offer reliable protection in the multiple trauma patient.[3]

Low-dose heparin (LDH) is considered the gold standard, and other available methods are compared to it in their efficacy. Low-dose heparin is defined as 5,000 units of heparin given subcutaneously every 8 to 12 hours. Although this does not affect coagulation parameters, it can induce thrombocytopenia, and may cause bleeding in traumatic central nervous system lesions. It appears that heparin, given every 8 hours, is more effective in achieving prophylaxis than when given every 12 hours, without increasing the risk of hemorrhagic complications.[21]

Low-dose warfarin has been used in orthopedic surgery for prophylaxis; because of bleeding complications and because it has to be administered in oral form, low-dose warfarin is not feasible in the multiple-injured patient.[3,38]

Dextran has been used with mixed results. Because dextran has more bleeding complications and negative effects on renal function, and is more expensive, it has not gained widespread acceptance.[3,22]

Whereas the previous methods attempt to combat the increased tendency to thromboembolism pharmacologically, there are a number of mechanical devices on the market supporting and sustaining continued venous flow with the goal of avoiding stasis and clotting.

Both graded elastic stockings and pneumatic compression devices have proved to be effective in preventing deep venous thrombosis in the nontrauma setting.[23] There may be an additive effect when used conjointly[24] and intermittent sequential compression devices of calf and thigh may be superior to calf-only devices. This reflects the natural history of deep venous thrombosis, with clot extension above the knee as the greatest risk in developing pulmonary embolism.[25] There also are reports that the effect of these mechanical devices is not so much due to improving flow but is due to increasing fibrinolytic activity.[26] It is not known whether these devices will prevent pulmonary embolism; it is likely that they prevent deep vein thrombosis, an accepted marker for pulmonary embolism.

It is essential to properly fit and apply these devices, and although they do not cause hemorrhagic complications, their major drawback is lack of patient/nursing compliance.

The increased risk for deep venous thrombosis/pulmonary embolism in trauma is proved beyond any doubt, and as the described methods appear to benefit some patients, the authors manage all trauma patients with some form of prophylaxis:

1. Timing of prophylaxis is essential and should start as soon as possible, ideally in the trauma admitting area.[3]

2. The combination of low-dose heparin and sequential intermittent compression device may be superior to any other re-

gimen and should be used in any patient who does not have a contraindication to heparin[3,27] or cannot wear a compression device because of presence of a cast, external fixator, traction, or open wounds.

3. Patients who, because of their injuries, cannot receive either anticoagulant or mechanical prophylaxis,[27] should be considered for prophylactic Greenfield filter insertion.[3]

4. Do not use aspirin, dipyridamole, or dihydroergotamine because of lack of proved benefit and significant side effects. ■

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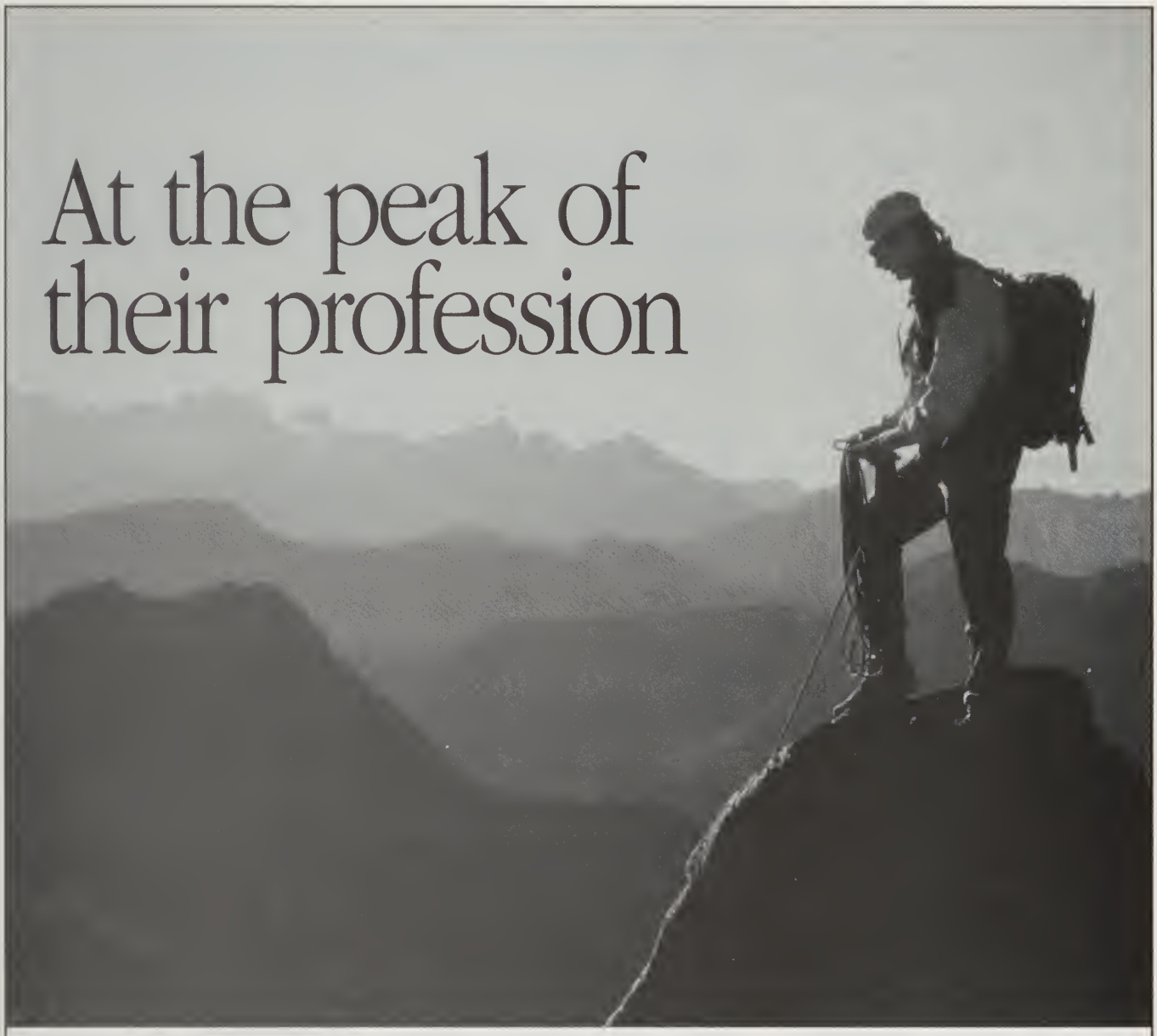
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The authors are affiliated with Cooper Hospital/University Medical Center, Camden: Dr. Rehm is assistant professor of surgery, Dr. Spence is head, Section of Vascular Surgery, and Dr. Ross is head, Division of Trauma and Emergency Surgical Services.

The paper was submitted in November 1991 and accepted in February 1992.

Address reprint requests to Dr. Rehm, Division of Trauma, Three Cooper Plaza, Suite 411, Camden, NJ 08103.



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Omeprazole in the Treatment of Peptic Ulcers and Gastroesophageal Reflux Disease

Mitchell S. Cappell, MD, PhD

Omeprazole blocks the final step of gastric acid secretion by blocking the proton pump (the hydrogen and potassium ATPase) in gastric parietal cells. Due to this direct action, omeprazole is the most potent, clinically available suppressor of gastric acidity.

It is important for physicians to be educated about the indications, therapeutic benefits, and safety of new medications. During the past 15 years, several new medications have been approved for the treatment of peptic ulcer disease including histamine-2 (H_2) receptor antagonists, misoprostol, sucralfate, and omeprazole.

This article reviews the mechanism of action, pharmacology, current therapeutic indications, and safety of omeprazole, the newest medication in the clinician's armamentarium against peptic ulcers and gastroesophageal reflux disease (GERD).

The final step of gastric acid secretion is the exchange of potassium in the gastric lumen for hydrogen ions, mediated by the proton pump (hydrogen and potassium dependent ATPase), located in the gastric parietal cell.[1,2] Omeprazole is the only clinically available agent that directly blocks the proton pump enzyme.[1] In contrast, H_2 antagonists, such as ranitidine, indirectly inhibit acid secretion by blocking histamine-mediated stimulation of the proton pump enzyme.[3] Due to a direct action, omeprazole is the most potent, clinically available suppressor of gastric acidity.[4]

PHARMACOLOGY

Omeprazole is a substituted benzimidazole that has a sulfinyl group. It is chemically inactive at a neutral pH. In the acidic milieu of the parietal cell, this sulfinyl group becomes protonated and irreversibly binds by disulfide linkage to sulfhydryl groups on the proton pump enzyme.[5] The bound proton pump enzyme permanently is inhibited and acid secretion recovers only when new unbound proton pump enzyme is synthesized.

Omeprazole is supplied in 20 mg capsules for oral administration. The capsule has an enteric coating because of the development of unstable metabolites in the presence of gastric acidity.[6,7] To prevent disruption of the enteric coating, the tablet should not be chewed or crushed prior to ingestion. About 70 percent of orally administered omeprazole is absorbed. Omeprazole has a plasma half-life of about one hour, but a much longer duration of action due to concentration and binding in the parietal cell.[8] It primarily is cleared and metabolized by the liver. The metabolites are excreted by the kidneys. Serum levels of omeprazole are not greatly affected by hepatic dysfunction, renal impairment, or advanced age and dosage adjustments are not necessary in these groups.[9,10]

A single 20 mg dose inhibits up to 70 percent of gastric acid secretion starting about six hours after ingestion. Treatment with 40 mg daily for one week results in greater than 95 percent inhibition of gastric acid secretion.[5] Duration of acid inhibition is about 72 hours. Omeprazole insignificantly affects gastric motility, lower esophageal sphincter pressure, and gastric secretion of pepsin or intrinsic factor.

INDICATIONS

The usual dosage for treatment of peptic ulcers or reflux esophagitis is 20 mg once daily (Table). It usually is given in the morning on an empty stomach to enhance absorption. Because of its potency, it particularly is valuable in patients with severe disease or disease refractory to therapy with H_2 antagonists.[11] Omeprazole is at least as effective as H_2 antagonists in the treatment of severe erosive esophagitis; severe esophagitis will heal in up to 85 percent of patients treated with omeprazole 60 mg daily. It is at least as effective as H_2 antagonists in healing peptic ulcers, but ulcers seem to heal faster on omeprazole.[7,12-14] Physicians increasingly are using the medication as first line therapy for

Table. *A summary of the indications, dosage, and side effects of omeprazole.*

Omeprazole is a gastric proton pump (hydrogen-potassium ATPase) inhibitor that potently suppresses gastric acid secretion. It is approved for the treatment of duodenal peptic ulcers, severe erosive esophagitis, gastroesophageal reflux disease (GERD) refractory to other therapies, and Zollinger-Ellison syndrome.

Class	Proton pump inhibitor.
Indications	Duodenal ulcer. Severe erosive esophagitis. Refractory GERD. Zollinger-Ellison syndrome.
Contraindications	Hypersensitivity to the product.
Dosage	For peptic ulcers or gastroesophageal reflux disease—20 mg once daily, can increase to 80 mg daily if required. For Zollinger-Ellison syndrome—60 mg daily or more. Divided daily doses for dosage greater than 80 mg daily. Capsules are not to be opened, chewed, or crushed prior to swallowing. Currently not approved for more than eight weeks of therapy except with Zollinger-Ellison syndrome.
Adverse Effects	Asymptomatic elevation of serum gastrin level. Long-term usage at exceedingly high dosage caused carcinoid tumors in rats but not in mice or dogs. No evidence of carcinoid tumors in man.
Drug Interactions	Mild interaction with warfarin and phenytoin.
How Supplied	20 mg capsules.

moderate reflux esophagitis and peptic duodenal or gastric ulcers. However, currently it is approved for four weeks in the treatment of all duodenal ulcers, and for up to eight weeks in the treatment of severe erosive esophagitis and of gastroesophageal reflux refractory to other therapy. Patients with severe disease who respond partly to eight weeks of therapy are eligible to receive another four-to-eight-week course of therapy. Low-dose maintenance therapy may have a future role in preventing recurrence of ulcers or esophagitis, but omeprazole is not currently approved in the United States for maintenance therapy.

Patients with Zollinger-Ellison syndrome develop a severe ulcer diathesis often associated with diarrhea as a result of excessive gastrin and hydrochloric acid secretion. Omeprazole is becoming the medication of choice for this hypersecretory state because of potent acid suppression and long duration of action.[15] Omeprazole therapy promotes ulcer healing and decreases diarrhea and abdominal pain in such patients. The initial dosage for this indication is 60 mg daily, but up to 120 mg three times daily may be required (Table). A dosage greater than 80 mg per day should be administered in divided doses.

SIDE EFFECTS

Omeprazole appears to be an extremely safe medication when used for up to eight weeks of therapy. This has been established in clinical studies involving over 19,000 patients. Safety has not been established in children. About 3 percent of patients experience gastrointestinal side effects including nausea, diarrhea, and abdominal pain.[16] These effects usually are mild and occur with equal frequency with placebo administration. Central nervous system effects of headache, dizziness, and somnolence occur infrequently. Occasional side effects include skin rash, leukopenia, or possibly transient elevation of the serum levels of hepatic aminotransferases. Bacterial overgrowth in the intestinal tract can occur with chronic administration of H_2 antagonists due to the loss of gastric acidity. Nosocomial pneumonia and decreased absorption are theoretical consequences of bacterial overgrowth. These effects have not been established with omeprazole therapy.[5]

Omeprazole interacts with the cytochrome P_{450} system in vitro. Concomitant omeprazole administration mildly raises the serum levels of diazepam, warfarin, and phenytoin by decreasing hepatic clearance.[17] The clinical significance of these effects is unknown, but it is prudent to monitor the serum levels of warfarin and phenytoin while instituting omeprazole therapy.

About 30 percent of rats administered for two years about 100 times the clinically equivalent dosage of omeprazole develop carcinoid tumors.[18] The tumors occurred primarily in female rats. These effects are not evident when rats are administered the dosage equivalent used in humans. Omeprazole has not been associated with carcinoid tumors in experimental studies in mice and dogs using high dosages, or in human trials using the clinically recommended dosages.[5,8]

Omeprazole does not appear to be mutagenic.[19] Omeprazole is believed to indirectly cause carcinoid tumors by increasing serum gastrin levels. Gastrin production is physiologically suppressed by gastric acidity. Chronic high-dose omeprazole therapy causes profound hypochlorhydria (anacidity) that leads to an approximately tenfold elevation of the serum gastrin level in rats. Hypergastrinemia produces hyperplasia of gastric

tissue, particularly of enterochromaffin-like (ECL) cells.[18,20] Carcinoid tumors are believed to develop from these cells. Antrectomy prevents the development of hypergastrinemia and carcinoid tumors in rats, suggesting that omeprazole does not directly induce tumor development.[18]

Chronic therapy with omeprazole 20 mg daily leads to only a doubling of the serum gastrin level in human subjects.[21] The level normalizes within two weeks of medication discontinuation. In contrast, H_2 antagonists typically produce about a 50 percent rise of the serum gastrin level. It seems highly unlikely that the modest transient gastrin level elevation due to omeprazole therapy for eight weeks or less would lead to a significantly increased risk of developing carcinoid tumors. The long-term risk of developing carcinoid tumors with chronic omeprazole therapy in humans is unknown. This consideration should not militate against chronic use of omeprazole in patients with Zollinger-Ellison syndrome because of the great risks of inadequate medical control of this disease. Patients requiring long-term omeprazole therapy should be informed that omeprazole has been associated with carcinoid tumors in rats, but not in other experimental animals or humans. ■

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Dr. Cappell is director of the Gastrointestinal Motility and Laser Endoscopy Unit, and assistant professor of medicine, UMDNJ-Robert Wood Johnson Medical School, New Brunswick.

The paper was submitted in March 1992 and accepted in April 1992.

Address reprint requests to Dr. Cappell, Department of Medicine/Gastroenterology, UMDNJ-Robert Wood Johnson Medical School, New Brunswick, NJ 08903-0019.

Editorial Comment. This class of drug has tremendous importance and value in the treatment of acid-related diseases. Most clinical studies report faster symptom relief and faster rates of healing for peptic ulcers and esophagitis than other therapies. Preliminary studies using intravenous omeprazole for the treatment of bleeding ulcers are encouraging and, finally, may be the pharmacologic agent that has efficacy in this setting. More controlled studies and long-term safety profiles are awaited. □ Steven C. Fiske, MD

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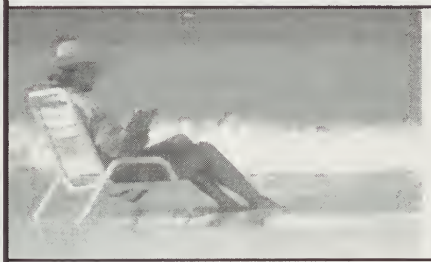
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General Surgery: Is There a Future?

James W. Knecht, MD

General surgery may not survive in an age of superspecialization unless the emphasis of general surgical training shifts from broad competence to defined areas of expertise. The author presents suggestions for restructuring general surgery residency requirements.

Superspecialization existed in medieval times. There were bladder stone extractors, cataract removers, cleft-lip operators, and herniotomists.[1] A physician chose one of these barber-surgeons to perform operations because he would comply with the physician's instructions without questioning the need for the operation.[2] Moreover, the patient was returned to the physician's care upon completion of the operation. In the 19th century, specialization was vehemently opposed by many in the profession who felt it was detrimental to the patient. Ethical practitioners regarded any physician who established himself to treat one group of diseases or organ system with suspicion, as it smacked too much of tradesmanship.[3] The opportunity for commanding higher fees, working shorter hours, and receiving greater respect, were all reasons for specialization.

Now self-proclaimed superspecialists such as hernia, breast, hemorrhoid, and laser surgeons advertise, proclaiming expertise in their restricted and limited areas of practice. Lundberg described the current situation as medicine's rocking horse: On one end of the rocker is professionalism and on the opposite end of the rocker is business.[4] Lundberg feels we now are at a time when greed has become too dominant an ethic.

However, Deysine supports the claim of the superspecialist by reporting lower recurrence rates when hernia surgery is performed by herniorrhaphists on a hernia service.[5] Roe states that specialists acknowledge their limitations and choose to identify with a sector that they can reasonably master.[6] He says that in the present competitive climate of an urban medical community, a surgeon is well advised to concentrate his activity in the sphere in which he has achieved sufficient expertise to provide patients with the highest available standard of care. The specialist has added expertise to competence.

Griffen disagrees with Roe's opinions regarding competence versus expertise.[7] He expresses the other viewpoint, which he terms the "bicycle hypothesis." Once you learn to ride a bicycle thoroughly and expertly, you can ride it again at any time in your life. This may be true of many surgical procedures. How many procedures must a surgeon perform to remain facile in doing that procedure? Surgeons past age 50 remember setting fractures, performing hysterectomies, hand surgery, thoracic surgery, and pediatric surgery. General surgeons now rarely treat fractures and perform hysterectomies, except in rural areas. The only pediatric surgery general surgeons now perform are appendectomies and, occasionally, hernias. General surgeons are not given thoracic surgical privileges. Hand surgeons have taken hand surgery away from not only general surgery, but from orthopedic and plastic surgery as well. General surgeons still do most of the colorectal surgery.

The first American surgical specialty board created was ophthalmology (1916), followed by otolaryngology (1924), obstetrics and gynecology (1930), orthopedics (1934), urology (1935), general surgery (1937), neurosurgery (1940), plastic surgery (1941), and thoracic surgery (1948). In 1949, the Board of Rectal Surgery, originally founded in 1935, changed its name to the Board of Colon and Rectal Surgery, enlarging its anatomic limits of jurisdiction from the rectum to the ileocecal valve.[8]

What has been called the "fragmentation" of general surgery has been increasing. Pediatric surgeons in 1972 and vascular surgeons in 1982 were granted certificates of special qualification. In 1984, critical care specialists and, in 1986, hand

- A discipline having a central core of knowledge embracing
  1. Anatomy and physiology
  2. Pathology and wound healing
  3. Metabolism and nutrition
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  6. Immunology and neoplasia
- The general surgeon has specialized knowledge and skill relating to the diagnosis, and the preoperative, operative, and postoperative management in the following:
  1. Alimentary tract
  2. Abdomen and its contents
  3. Breast, skin, and soft tissue
  4. Head and neck
  5. Vascular system (excluding intracranial and cardiac)
  6. Endocrine system
  7. Surgical oncology
  8. Comprehensive management of trauma
  9. Complete care of critically ill patients

Figure 1. ***The specialty of general surgery as defined by the American Board of Surgery.***

surgeons were granted certificates of added qualification. As of 1990, only certificates of added qualification will be granted to vascular surgeons. Trauma, oncologic, head and neck, and transplantation surgeons also are seeking added or special certificates. Certificates given in recognition of extra training have been used to restrict privileges of general surgeons. Is "general surgery" to continue to become less general? Is general surgery to be only leftovers? The Council on Long-Range Planning of the American Medical Association estimates, that with the aging of the population, the utilization of the services of general surgeons will increase by 16 to 19 percent while the supply of general surgeons will increase by only 6 percent between 1986 and 2000. How much of what was called "general surgery" in 1986 will be left by the year 2000?

In 1984, Higgins asked if there should be an American Board of Residual Surgery, with an emblem featuring a hernia, a gallbladder, and an appendix.[10] Now, the hernia, gallbladder, and appendix might be removed from the emblem by the laparoscopists.

Let us examine what procedures remain for the residual surgeons: Minor surgery on the skin and subcutaneous tissues will be performed with lasers by dermatologists in their offices. Thyroid and parathyroid surgery will be divided among otolaryngologists and head and neck surgeons. Surgery on the stomach and duodenum has decreased. The control of gastric acid production by H_2 blockers has markedly reduced the need for surgery for peptic ulcers. A few patients will bleed massively or perforate and need emergency surgery. The incidence of gastric cancer has decreased for unknown reasons. Laparoscopic vagotomy-pyloromyotomy might replace what little elective peptic ulcer surgery is being done. Gallbladder and biliary surgery are being threatened by nonoperative treatments such as lithotripsy and stone-dissolving drugs administered by radiologists and gastroenterologists. Will laparoscopic surgery save us? Or will laparoscopic surgeons extract the gallbladder from general surgery? The spleen will belong to the trauma surgeon. Oncologic surgeons will remove spleens electively and perform pancreas and liver surgery. They also will place the intravenous and intra-arterial lines and pumps for infusions. Intestinal obstructions belong to the general surgeon. But intestinal obstructions will occur less frequently. Adhesions will decrease as laparotomies are replaced by nonoperative and laparoscopic treatments.

Perhaps the only real general surgery will be performed by trauma surgeons. Pories states that when the job description no longer fits the job, it is time to re-examine the task and its purpose.[11] If general surgery is to survive, the general surgical curriculum must be restructured. The current requirements of the American Board of Surgery are available (Figures 1 and 2). The Board defines areas of primary responsibility, areas of significant experience, and areas of understanding, but does not clearly state areas of expertise. The Board is too general.

Dr. Wexler, a Canadian surgeon, asserts that the image of the general surgeon is suffering in the eyes of peers, trainees, the public, and general surgeons themselves: "People see the general surgeon as just a generalist, and prefer what they consider to be specialists."[12]

The following suggestions are my own, and are based on 27 years of surgical experience as a resident, practicing general surgeon, and surgical educator. A number of surgeon-educators have made differing suggestions.[13-15]

A "core" surgical curriculum should be the starting point of all surgical residencies. The core curriculum requires one to two years of didactic training in basic science, as well as in patient care. The next three to four years is devoted to specialty training. General surgery would be considered as one of the specialties.

The areas of primary responsibility as defined by the American Board of Surgery, which include head and neck, the

vascular system, endocrine system, surgical oncology, comprehensive management of trauma, and complete care of critically injured patients, would be viewed as areas of competence. But expertise must be obtained in hernia surgery, breast surgery, laparoscopic surgery, endoscopic surgery, and all abdominal surgery, including colon and rectal surgery. Surgical endoscopy suites must be established to train surgical residents and staff.[16]

The scope of general surgery had been contracting until laparoscopic surgery was introduced to the general surgical world in 1989. Laparoscopic surgery may replace much of the open abdominal surgery being performed by general surgeons and must be a major component of the curriculum.

To avoid prolonging the residency, eliminate formal rotations on urology, ENT, cardiac surgery, plastic (cosmetic) surgery, orthopedics, neurosurgery, and transplant surgery. Surgical residents can scrub on open urologic procedures and head and neck cancer surgery by cooperative arrangements with the respective specialists. Incorporate into a comprehensive, multidiscipline, and multisystem trauma program, neurosurgical evaluation, computed tomography (CT) and magnetic resonance imaging (MRI) scan interpretation, neck exploration, skin grafting, flaps, and tissue transfer techniques, and urologic procedures such as bladder repair and nephrectomy. The general surgeon must be able to remove a uterus. Cooperation with gynecologists is essential.

Residents wishing to pursue an academic career can elect to spend additional time completing laboratory research or taking additional training in fields such as transplantation.

We must not forget the ongoing training of the practicing general surgeon. Those in practice must receive additional training to keep up to date. We are too valuable to be made obsolete by a system that discourages learning new skills. Presently, there is a rush to learn laparoscopic surgery. I sense this rush, in part, is due to fear of not getting in on the ground floor and getting privileges.

There is an ongoing turf war over endoscopy and the teaching of endoscopy to general surgeons in practice. Some gastroenterologists want surgeons to take fellowships in colon and rectal surgery before granting them endoscopic privileges. Efforts to train general surgeons in endoscopy at their own institutions should be encouraged.

Mini-fellowships and animal laboratories could be established to train general surgeons in endoscopy, laparoscopy, laser surgery, trauma surgery, intensive care, and new vascular procedures. A surgeon can use a week or a month to learn new skills; it would be unreasonable to expect him to abandon a practice for a fellowship lasting one or two years. Our educational needs are not being met by current postgraduate slide and lecture-oriented courses given at national or regional meetings.

Dr. John Mannick in his 1990 address before the American Surgical Association titled, "Who Killed General Surgery?" answered his question stating perhaps we all did, if we are talking about abandonment of a surgical practice that encompasses all components of general surgery as defined by the American Board of Surgery.[17] However, general surgical training still is alive and well, when we are talking about a broadly based, five-year surgical residency with graded responsibilities. My fear is that a general surgical residency may be preserved, but no practicing general surgeons produced. The residency will be preliminary training before entering a surgical subspecialty.

Should we concede that general surgery as a practicing specialty is obsolete and has no future? Should a few institutions train only a small number of general surgeons for rural areas? Let us not abandon general surgery. We need to redefine general surgery. We need to ensure areas of expertise so the public will see the general surgeon as a specialist and not a generalist. We need to stress the cost savings, the fewer costly, unpleasant, and unnecessary tests, and shorter hospitalizations, when general surgeons admit, diagnose, and treat surgically related conditions.[18] We need to convince the public that it is in its interest to have a surgeon with broad training and experience to treat the whole patient and not just an organ.

The challenge is ours. If we fail, will we all have to pick an organ and proclaim our expertise to the consumer through radio, television, and newspaper advertisements? ■

General Surgeon

- Is expected to have significant experience in pediatric, plastic, and general thoracic surgery.
- Must have understanding of the management of the more common problems in cardiac, gynecologic, orthopedic, transplant, and urologic surgery, and of the administration of anesthetic agents.
- Must be capable of employing endoscopic techniques particularly proctosigmoidoscopy and operative choledochoscopy.
- Must have experience with a variety of other techniques such as laryngoscopy, bronchoscopy, esophagogastroduodenoscopy, colonoscopy, and peritoneoscopy.
- It is desirable that the general surgeon have opportunity to gain some knowledge and experience of evolving technology such as lasers, lithotripsy, and endoscopic operations.

Figure 2. ***The general surgeon.***

Dr. Knecht is surgical program coordinator, Monmouth Medical Center-Jersey Shore Medical Center Joint Surgical Residency Program; clinical

assistant professor of surgery, Hahnemann University, Philadelphia; and attending, Department of Surgery, Jersey Shore Medical Center, Neptune, and Monmouth Medical Center, Long Branch. The paper was submitted in March 1992 and accepted in April 1992. Address reprint requests to Dr. Knecht, Jersey Shore Medical Center, Neptune, NJ 07753.

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Completeness of Case Ascertainment of the State Cancer Registry

Allen Kraut, MD
Eva Chan, MSc
Toshi Abe, MSW
Nancy E.L. Hall, PhD
Philip J. Landrigan, MD, MSc

The authors evaluated the ability of the New Jersey State Cancer Registry to detect known cancer cases during an investigation of a cancer cluster occurring in professional football players. The Registry was found to be a valuable tool for the detection of cancer cases for New Jersey residents.

Due to its extensive industrial base, New Jersy has been the site of numerous occupational and environmental cancer investigations.[1-10] The New Jersey State Cancer Registry (NJSCR) is a statewide, population-based incidence registry that has been used for some of these analyses. However, to date, no reports of its ability to identify known cancer cases have appeared in the literature. We report our experience with regards to the usefulness of NJSCR as a case identification instrument during a cancer cluster evaluation of a group of professional football players.

In 1976, the New York Giants professional football team relocated to the newly constructed Meadowlands Sports Complex (MSC) in East Rutherford. Between 1980 and 1987, four team members developed cancer: one case each of non-Hodgkin's lymphoma, glioblastoma, angiosarcoma, and Hodgkin's disease. Based on an assessment of environmental and epidemiologic data, it was concluded that the four cancer cases most likely were clustered by chance and not caused by environmental conditions present at MSC.[6] As NJSCR proved to be a very important tool in performing this investigation, an analysis of its ability to identify known cancer cases was important.

NJSCR was established by law[11] to collect all reports of newly diagnosed cases of cancer among New Jersey's approximately 7.6 million residents. Established in 1979, NJSCR collects almost 40,000 reports of incident cases of cancer each year. From 1983 through 1989, NJSCR was a participant in the National Cancer Institute's Surveillance, Epidemiology, and End Result (SEER) program.

METHODS

Epidemiologic evaluation of the cancer cluster included proportionate mortality and proportionate cancer incidence studies of the entire workforce employed at MSC. Complete employment listings were available from the major employers of the complex since its inception in late 1976. MSC employed 7,889 individuals for at least one day in each of two calendar years. For every individual, name, state of last residence while employed, and social security number were available. Birth date, gender, and racial information were available for a minority of the cohort members. For approximately 90 percent of the employees, the last available address was in New Jersey.

To assess the ability of NJSCR to identify known cancer cases among New Jersey residents, a comparison was made of cancer cases identified from three other sources (a death certificate review from the mortality study, employer/union records, and a questionnaire sent to all current employees), and the cancer registry itself.

A computer tape listing all cohort members with available demographic information was submitted to NJSCR for data linkage. At the time of the study, NJSCR had complete incidence data for the period 1979 through 1985. New Jersey residents diagnosed with cancer at hospitals in New York, Pennsylvania, and Delaware are reported to NJSCR under reciprocal reporting agreements.

The employee list was matched to the registry files using a COBOL computer program utilizing varied combinations of a phonetic representation of the last name, first initial of first name, date of birth, gender, race, and social security number. Last name was encrypted using a modified algorithm originally developed for the New York State Identification and Intelligence System (NYSIIS). As a result of review

and identification of possible and exact matches, NJSCR found a total of 132 individuals reported as having had cancer after beginning employment at the sports complex betwen 1978 and 1988. Of these, 89 individuals were diagnosed between 1979 and 1985.

For the 1979 to 1985 period, 49 death certificates were identified on which cancer was reported as either the cause of death or as a coexisting condition. During these years, 25 incident cancer cases were identified from employer and union records and the questionnaire. Medical record review confirmed the cancer diagnosis for all individuals responding to the questionnaire.

Reports of cancer without confirmation from either the cancer registry, death certificate notation, or medical record review were not included in the analysis. No individual was identified whose sole proof of cancer was acceptance of medical claims by union or management health plans.

RESULTS

For the years 1979 to 1985, NJSCR identified 89 of the 90 cases used in the cancer incidence study compared to 54 cases identified by the three other sources combined ($P < 0.0000001$). Thus, NJSCR is clearly more effective than relying on the other sources. For these years, it located 98 percent (53/54) of the cancer cases known from the other sources. The missed case, identified by death certificate review, was a New Jersey resident. As histologic evidence confirming this case is not available, it cannot be certain that this is a false negative.

CONCLUSIONS

From 1979 to 1985, NJSCR proved to be a very useful tool for the detection of cancer cases among residents of New Jersey. Therefore, it should be used as the primary data source for cancer incidence studies of New Jersey residents. ■

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Dr. Kraut is affiliated with the Departments of Internal Medicine and Community Health Sciences, University of Manitoba, Canada. Ms. Chan and Dr. Landrigan are affiliated with the Division of Environmental and Occupational Medicine, Department of Community Medicine, Mount Sinai Medical Center, New York. Mr. Abe and Dr. Hall are affiliated with the New Jersey State Department of Health, Trenton.

The paper was submitted in January 1992 and accepted in April 1992.

Address reprint requests to Dr. Kraut, University of Manitoba, NA 618, 700 McDermot Avenue, Winnipeg, Canada R3E OW3.

The New Jersey Health Care Delivery Structure—a Clarification

Sanford M. Lewis, MD

Recent SBME rules were developed from issues raised by a previous commissioner of health. SBME received comments on these issues at two public hearings. SBME drafted the rules to incorporate the substance and the principles of the state's Health Care Cost Reduction Act.

A recent article entitled, "SBME Overhauls Health Care Delivery Structure," by Steven I. Kern, Esquire (89:469-471, 1992) suggests that new rules *(N.J.A.C. 13:35-6.16* and *6.17)* of the State Board of Medical Examiners (SBME) will "eviscerate" recent regulatory efforts of federal and state governments to remove the profit motive from physician referrals to entities in which they have a financial interest. SBME finds this article inaccurate and seriously misreads current law, misinterprets the rules, and falsely accuses dedicated SBME members of self-interested conduct.

SBME rules were developed from issues raised by a prior New Jersey State Commissioner of Health, from problems coming to light in the course of investigation of consumer complaints, and from a growing public perception that some physicians were putting personal financial interests not merely well ahead of the interests of their patients, but sometimes clearly at variance with those interests. SBME received comment on how to approach these problems at two public hearings, and also considered analogous federal rules. SBME drafted the current rules to incorporate both the substance and the principles presented in radically new provisions of this state's Health Care Cost Reduction Act, all designed to reduce the potential for abusive practices and to provide guidance to responsible practitioners on conducting an ethical practice. Issues were analyzed and standards made applicable to all SBME licensees, taking into account varying potentials for abuse in diverse settings. In sharp contrast to the claims made in the cited article, readers should be aware of the following facts and SBME interpretation.

Licensee Combinations in a Professional Association (PA). Mr. Kern's article implies that the SBME rule invites practitioners to provide a variety of professional services within the same corporate structure and that this opportunity is somehow new, and a ready vehicle for evasion of protective laws and rules. SBME rules, however, simply implement current law. The Professional Service Corporations Act, since 1982, has permitted the formation of professional corporations containing "closely allied" professionals. The most recent amendment in 1991 expressly defines the term "closely allied professional services," in pertinent part, as "limited to the practice of ... (b) any branch of medicine and surgery, optometry, physical therapy, registered professional nursing, and dentistry." The SBME rule is correct in its interpretation that licensed health care professionals may be deemed "closely allied." The new rule's wording allowing licensees more than one profession to offer services in a single PA format (where not prohibited by other law or rules), thus, is completely consistent with the Legislature's express policy to permit health care professionals to associate with one another in this corporate form. Strong policy arguments exist for effective delivery of professional services, within a single office setting, by a health care entity that offers treatment appropriate for patient needs allocated among different types of licensees, each having some equity interest in the entity. Examples include a psychiatrist, psychologist, and social worker; or a medical doctor and chiropractor. However, the summary of public comment accompanying the rule adoption for *6.16(c)* explicitly noted SBME's concern as to how the law's definition of "closely allied" will be implemented, and indicated that the practical safety of licensee combinations will be determined in the future. If experience discloses inappropriate division of services for which in-

dividual disciplinary action seems insufficient, SBME stands ready to make corrective rule amendments.

Collusive Referrals. Accepted standards of practice in each profession still will govern the reasonableness of conduct of each licensee including any referral to a "partner" professional. In the absence of evidence, SBME will not presume a conspiracy among PA's shareholders to engage in improper conduct, and the rule does not expand any prior opportunity to do this. Suspicions of "ping-ponging" referrals will be evaluated by fair inquiry into patterns of medically unjustifiable conduct and other investigative tools. Indeed, it is likely that inappropriate referrals will be detected more easily under the new rules than were identified among practitioners who are nominally "independent." The regulatory alternative of totally prohibiting a "referral" to a bona fide partner might prevent some abuse, but only at the expense of legitimate considerations for better treatment options for patients. SBME found that prohibition was unwarranted at this time. Again, if experience discloses abuse, SBME will consider modifying amendments.

Subversion of Anti-Kickback Laws/Rules by Contractual Arrangements with Nonlicensed Entities. Mr. Kern's article advances an interpretation of *6.16(f)(5)* regarding limited and general partnerships resulting in untoward public consequences. It asserts that nonprofessionals now may directly invest in the professional delivery of health care and may profit as a partner in that enterprise, and, accordingly, public harm will arise. The rule contemplates no such association. The SBME rule will permit the establishment of a limited partnership composed of doctors having a business relationship with a nonprofessional general partner, but only for the limited purpose of permitting the nonlicensee partner to render administrative services. The rule continues to require that professional services be offered solely through the individuals authorized to render such services. Only licensed health care professionals can own and operate the entity, determine office policies, and set fees. Those professionals will be personally accountable to their respective boards. SBME licensees will have even a larger personal accountability by virtue of the policy-oversight requirements of *6.16(b)*. The nonlicensee partner is expressly limited to providing administrative services, and cannot engage in the practice of medicine. It should be well understood that any SBME licensee who enters into a contract with a nonlicensed entity within the partnership setting—whether for real estate or management or equipment—must retain the right to terminate the contract if the physician finds that any aspect of the contract threatens the physician's ability to carry out professional obligations. In no event should a nonprofessional "partnership" have the right to "lock in" a physician's medical practice.

Interactive Rule Provisions. The two new SBME rules also contain a number of interacting provisions that serve both to reduce abuse and to make it easier to discover abuse. The underlying statute, *N.J.S.A. 45:9-22.4* et seq, imposes referral limitations on any physician, podiatrist, or chiropractor who has any financial interest (personally or through designated family relationships) in a health care service. The term "health care service" is given a comprehensive definition including all forms of medical care whether in or out of a hospital. The SBME rule requires the interest to be disclosed to SBME for filing as a public notice, whether or not the licensee refers patients to the entity. In addition, an entity operating under a PA name must list on its bill the names of all licensees having an ownership interest. If the PA is a multi-licensee practice, the scopes of practice must be designated. Rule *6.17* gives particular attention to those specialty categories that, to date, have demonstrated the highest abuse potential: ophthalmology, radiology, physical therapy, and laboratory services. Other protections for heightening consumer alertness are found in separate SBME rule *6.1* that requires name and practice identification of licensees on all office representations including billing, and in a proposed amendment to patient record rule *6.5* that requires that a bill disclose the name of the licensed provider of service. These provisions, in addition to others not listed here, should substantially check abuse by identifying referral interests. SBME also will rely upon principles of quality assurance and professional justification to evaluate suspect referrals.

Additional enforcement support is expected to come from *6.17* that forbids giving of any form of compensation, to any licensed or unlicensed source, which a reasonable person would recognize as having been given or received in appreciation for—or to promote certain conduct—by a licensee. Thus, even though the patient record does not show improper referrals, where SBME's investigation discloses a collusive factual pattern, the licensees involved will face disciplinary review.

Still another provision tending to discourage inappropriate licensee combinations and conduct is found in *6.17(e)* that limits fees that can be charged for items prescribed by the physician and then sold by that medical entity to the patient. If a health care practice contains multiple kinds of licensees, all licensees must operate under the same office name. Thus, a doctor practicing with a pharmacist cannot subvert the prohibitions in the Health Care Cost Reduction Act and the rule, because all providers of

goods at that entity filling the prescription of the prescribing physician will be bound by that physician's charge limitations.*

Finally, *6.17(g)* requires that licensees investing in a health care services entity be paid only on the basis of return on monetary investment. While this provision may theoretically be abused by practitioners engaging in "ping-ponging" within a PA, again, the danger would appear to be no greater in practical effect after the rule adoption than it was before.

SUMMARY

SBME rules, either in intent or effect, do not undercut federal or state initiatives to foster competition, or to prevent kickbacks or other types of fraud. On the contrary, SBME has deliberately taken a conservative approach in order not to prohibit the development of practice innovations having the potential to provide health care benefits to the public. The rules draw the line at the point where licensees may be induced—wittingly or unwittingly—by unprincipled business entrepreneurs to engage in commercial practices not conducive to the public interest. This is a measured administrative response to the current medical marketplace that will continue to receive ongoing scrutiny and, contrary to Mr. Kern's article, possesses the potential for corrective input through diligent oversight that SBME intends to provide.

It is important for all interested parties to fully understand that SBME, composed of physicians, lay members, government representatives, and a laboratory director, is not a monolith in which "self-interest" can play a significant role. All matters are thoroughly investigated, debated, and subjected to intensive legal scrutiny. Federal and state legislation often provide parameters that SBME is required to implement. The problems discussed briefly in this essay represent many months of continued efforts by members of SBME, consultants, attorneys, the profession, and the public through hearings and written communication. We are all engaged in fortifying the public welfare. The "new" measures were promulgated in the light of these multiple and compelling considerations. ■

*Rule section, *6.17(e)*, was placed on temporary hold by SBME until August 11, 1992, to provide an opportunity for protesting ophthalmologists and otolaryngologists to support their contention that the section, as currently worded, did not allow them to recoup actual expenses in prescribing and selling eyewear and hearing aids.

Dr. Lewis is president, State Board of Medical Examiners. Address reprint requests to Dr. Lewis, SBME, 28 West State Street, Trenton, NJ 08608.

Editorial Note: Obviously, Mr. Kern and Dr. Lewis have a difference of opinion over the merits, impact, and ultimately the effect of the newly adopted rules (*N.J.A.C. 13:35-6.16* and *6.17*). The history of the proposal is a puzzlement. As Dr. Lewis pointed out, the point of origin was a request of a former New Jersey State Commissioner of Health, Dr. Richard Goldstein. Dr. Lewis did not mention that when SBME held a hearing on that request, Dr. Goldstein testified against it, stated publicly that it was ill advised, and indicated that no action was necessary since he had learned that his concerns were not well founded and the end result would prevent hospital-physician joint ventures. Beyond that, it is a matter of public record that Dr. Goldstein testified this spring before the Senate Health Committee and reaffirmed that he had been mistaken. He urged the senators to begin repealing the laws that Dr. Lewis urges as the foundation of the regulations.

A final point of notation is that the SBME vote on the rules was not unanimous and that SBME had issued stays regarding two different sections of the adopted regulations. There are confusing sections that require clarification. We can only hope that SBME will keep open the door for discussion, explanation, refinement, and revision. □ Vincent A. Maressa, JD, Executive Director, MSNJ

CLIA-88 Final Rule: Part 2

Kathleen Voldish, CLA (ASCP)

Physicians performing moderate or high complexity tests will need to prepare their office laboratories to meet CLIA-88 government standards. Doctors who have not applied for their registration certificate should do so immediately. This is the second in a three-part series.

The final Clinical Laboratory Improvement Amendments (CLIA)-88 regulations were published in the *Federal Register* on February 28, 1992. Now, to continue office laboratory testing, physicians must have the appropriate certificate from the Health Care Finance Administration (HCFA). Physicians not acquiring this certificate will face a variety of sanctions, civil fines, and criminal penalties. Part 1 of this series (*NJ MED* 601-604, 1992) reviewed personnel requirements, test complexity levels, and certificate requirements. Part 2 will review the sanctions, office inspections, and proficiency testing.

SANCTIONS

All physician office laboratories (POLs) must have a certificate of waiver or registration certificate. CLIA-88 regulations apply to all physician office testing regardless of whether the physician participates in Medicare.

Failure to meet the requirements can result in a wide variety of sanctions, civil fines, and criminal penalties, including incarceration for any person convicted of intentionally violating CLIA.

The February 28, 1992, regulations include changes that are very fair and favorable to the physician. Newly regulated laboratories and privately accredited laboratories will not be sanctioned for deficiencies found during the first inspection, unless they pose immediate jeopardy to the public. Newly regulated laboratories that fail inspection will be advised of the deficiencies and given a correction action plan. The laboratory will be subject to periodic inspections during the following year to see if an effort is being made to correct problems. The physician will pay a fee for each subsequent inspection.

If the problem is not corrected during this period (one year), the laboratory will be subject to sanctions.

HCFA will impose sanctions on a case-by-case basis. The specific situation will dictate the sanction HCFA believes will motivate correction of a condition level deficiency. Condition level defiencies are defined as noncompliance with any of the conditions that a laboratory must meet to obtain a CLIA certificate, and have been categorized into three levels: condition level deficiencies posing immediate jeopardy, i.e. laboratory test results reported for tests that were not performed; condition level without immediate jeopardy, i.e. unsuccessful performance in a proficiency testing (PT) program; and lower level deficiencies, i.e. procedure manual lacking information.

At its discretion, HCFA can impose principal sanctions or intermediate sanctions or any combination of the two. Principal sanctions include suspension, limitation, or revocation of the CLIA certificate. The suspension of the certificate will cancel the laboratory's approval to receive Medicare payment for laboratory services. If the laboratory has a condition level deficiency, HCFA can impose one or more intermediate sanctions in lieu of principal sanctions, including:

1. A directed plan of correction to be completed within a specific time frame.
2. On-site monitoring by the state survey agency (the laboratory has to pay for this monitoring), to make sure that the laboratory is making the required improvements.
3. Civil penalties from $3,050-$10,000 per day or per violation for deficiencies that pose immediate jeopardy.
4. Civil penalties from $50 to $3,000 per day or per violation for deficiencies that do not impose immediate jeopardy.
5. For laboratories participating in Medicare, suspension of payments for individual tests in a

particular specialty or for the entire specialty.

Following an on-site inspection, laboratories will be notified of any deficiencies. Written notice of sanctions will be issued in 5 days if there is immediate jeopardy and 15 days if the situation does not pose immediate jeopardy. Laboratories have the right to appeal the sanctions; however, sanctions will remain in effect and the office will be obligated to comply with the sanctions prior to receiving a hearing. Deficient laboratory practices will not be allowed to continue while awaiting a hearing.

Specific information about laboratory performance will be published in the *Laboratory Registry* once a year. This *Registry* will be distributed to HCFA regional offices and will be available upon written request.

INSPECTIONS

Laboratories performing only waived tests will not be routinely inspected. However, HCFA can conduct inspections to investigate complaints or to ensure that only waived tests are being performed.

All previously unregulated office laboratories holding a registration certificate, or laboratories regulated through a private accreditation agency will be required to pass an inspection before being issued an accreditation certificate. In order to pass an inspection, a laboratory must be in complete compliance with all the requirements of the regulation. After the laboratory passes inspection and is issued a certificate, it will be inspected on a biennial basis. This inspection may be performed by the state, if its licensure program is approved by HCFA, or by an approved private nonprofit organization. Regulations governing the "deeming" process are expected to be released before September 1, 1992. Inspections can occur when complaints are filed against the laboratory.

Failure to permit an inspection will result in immediate suspension of Medicare and Medicaid payments and initiation of action to revoke the laboratory certificate. Inspection costs are not included in the certificate fee and will be based on the amount of tests the laboratory performs. Inspection fees will be assessed prior to inspection of the laboratory.

Fees for inspection start at $300 and increase according to test volume. If the laboratory fails the inspection and is given a correction plan, the laboratory must pay for all additional inspections until deficiencies are corrected (up to one year). Once again, previously unregulated laboratories will not have sanctions imposed after the first inspection unless the deficiency causes immediate jeopardy.

PROFICIENCY TESTING

Each laboratory performing tests of moderate and/or high complexity levels must enroll in an approved PT program for each specialty or subspecialty for which it seeks certification. The laboratory must notify HCFA of the program(s) for which it chooses to participate. Newly regulated laboratories must be enrolled by January 1, 1994. Penalties for unsuccessful PT will not start until 1995. The reason for the long delay in this area of the regulation is to allow PT programs to prepare for the enormous increase of demand for PT material. It is advantageous for POLs to have PT as soon as possible and become comfortable with this type of program.

Successful participation in a PT program is a score of 80 percent or higher for all test challenges. There are a few exceptions to this rule, including ABO grouping and D(Rho) typing and compatibility, which requires a 100 percent score. Two consecutive unsatisfactory scores, or unsatisfactory scores in two out of three consecutive testing events, is unsuccessful performance. If a laboratory's certificate is suspended and/or Medicare approval is terminated, the laboratory must demonstrate sustained successful performance on two consecutive PT events before HCFA will consider it for reinstatement for the certificate for the test, specialty, or subspecialty.

Failure to return PT results for a testing event is unsatisfactory performance and will be scored as a "0." If a laboratory is unable to perform PT, due to equipment or reagent problems, it will not receive a "0" as long as it states it did not perform patient tests during this time as well. A letter must accompany the PT test form describing the problem. Most POLs participating in PT do very well, scoring over 90 percent. If the laboratory has good quality assurance, quality control, and a maintenance program in place, there is no reason to fear PT.

If a laboratory sends the PT samples or portions of the samples to another laboratory for testing, the reference laboratory is required by law to report receiving the specimen and the laboratory that sent specimen will lose its certificate for a minimum of one year.

Costs of PT programs can vary greatly from program to program. A physician may do these analyses himself or hire a consultant to do the evaluation.

Part 3 of this series will focus upon quality control, quality assurance, laboratory maintenance, and general tips that will help the physician meet the CLIA-88 regulations. ■

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Ms. Voldish is a POL consultant and the New Jersey representative of the American Society of Clinical Pathologists.

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Address reprint requests to Ms. Voldish, POL Consultants, 1150 Concord Drive, Haddonfield, NJ 08033.

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Pietro Enzo DiFlorio, MD ..... Haddonfield
Gino Gonnella, MD ..... Edison
Rajendra Prasad (Gupta), MD ..... Trenton
Riaz Iqbal, MD ..... Trenton
Philip J. Jasper, MD ..... Passaic
Luz Morable-Naval, MD ..... Jersey City
Kutumba S. Pitta, MD ..... Toms River
Honesto N. Poblete, MD ..... Mercerville
Cesar Ravanzo, MD ..... Washington
Celia G. Roque, MD ..... Cranford
Paul A. Rossos, MD ..... Hamilton
Ajit S. Sodhi, MD ..... Edison

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John T. Harrigan, MD ..... Neptune
Thomas Hegyi, MD ..... New Brunswick
I. Mark Hiatt, MD ..... New Brunswick
David I. Hollander, MD ..... Springfield
Michael D. Horn, MD ..... Willingboro
Thomas R. Kay, MD ..... Marlton
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John J. LoCurto, Jr, MD ..... Hackensack
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Irving P. Ratner, MD ..... Cherry Hill
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Anthony M. Tonzola, MD ..... Westfield
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Jeanne Leisner, *Auxiliary Member*
..... Cape May Court House

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Christina Y. Chao, MD ..... Medford
Leticia V. DeCastro, MD ..... Edison
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Anita Falla, MD ..... Millburn
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Palma E. Formica, MD ..... New Brunswick
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Carolyn J. Horowitz, MD ..... Marlton
Satwant G. Keswani, MD ..... Livingston
Wendy Martinez, MD ..... Cherry Hill
Catherine A. Michon, MD ..... Somerdale
Eileen M. Moynihan, MD ..... Haddon Heights
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Phyllis M. Perkins, MD ..... Linwood
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Celia G. Roque, MD ..... Cranford
Sorosh Roshan, MD ..... Millburn
Elida Rouby, MD ..... Camden
Catherine E. Spears, MD ..... Chatham
Bessie M. Sullivan, MD ..... Edison
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(Arthur White, Staff Liaison)

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John A. Kline, MD ..... Linden
Mitchell N. Kotler, MD ..... Woodbury
Wendy Martinez, MD ..... Cherry Hill
Kenneth C. Peacock, MD ..... Mount Holly
Kutumba S. Pitta, MD ..... Toms River
Craig B. Quigley, MD ..... Carneys Point
Mohammad Shafi, MD ..... South Plainfield
Suzanne A. Widrow, MD ..... East Hanover
Valerie Claps, *Auxiliary Member* ..... Randolph
Joan M. Basic, CAE, *Consultant* ..... River Edge
Ardith R. Lane, *Consultant* ..... Voorhees
Mary Alice Bruno, *Consultant* ..... East Brunswick

DOCTORS' NOTEBOOK

TRUSTEES' MINUTES

A regular meeting of the Board of Trustees was held on July 19, 1992, at MSNJ headquarters in Lawrenceville. Detailed minutes are on file with the secretary of your county society. A summary of significant actions follows:

President's Report.

1. New Members and Appointments. Welcomed Herbert Langer, MD, medical specialty society representative, and Carlo Porcaro, MD, hospital medical staff section representative. Noted the appointment of Joseph A. Riggs, MD, as chairman, and Irving P. Ratner, MD, as vice-chairman, AMA delegation.

2. AMA Positions. Voted to sponsor and support the candidacy of Palma Formica, MD, for re-election to the AMA Board of Trustees. Also, voted to endorse and support the candidacy of Joseph A. Riggs, MD, for a position on the AMA Council on Scientific Affairs.

3. MSNJ Annual Meeting. Voted in favor of continuing the traditional annual meeting format, with an allowance for more efficient use of time in scheduling.

4. Uncompensated Care. Noted that MSNJ is attempting to draft an alternative to the Uncompensated Care Trust Fund.

Health Access America. Was supplied with copies of *Health Access America, Second Edition,* as well as a copy of *Advocacy Briefs* published by the AMA Office of Policy Communication and Advocacy Support.

Specialty Reports. Received reports from the MSNJ Auxiliary, the Academy of Medicine of New Jersey, the University of Medicine and Dentistry of New Jersey, and the New Jersey Hospital Association.

Report of Executive Director.

1. Political Coverage Sponsorship. Noted that MSNJ will cosponsor the New Jersey Network political campaign coverage.

2. Legislation. Noted the following: the New Jersey State Department of Health is proceeding with an analysis of the State Health Plan (A-1144/S-610); and if Governor Florio vetoes A-1117/S-599 (repealing the JUA surcharge on medical malpractice premiums), MSNJ will seek an over-ride in the Legislature.

3. Litigation. Noted the following: efforts will be made to discuss biennial licensing renewal with the State Board of Medical Examiners and if the opportunity to negotiate is not accepted, MSNJ is prepared to proceed with a federal action; decision was reached on Brachfeld versus the Medical Inter-Insurance Exchange stating, "There will be no interest to the plaintiffs on the subordinated loan certificate; the authority to authorize the redemption of the certificate presides in the commissioner of insurance; judgment is entered in favor of the defendant; case is dismissed with prejudice"; and a brief was filed by MSNJ and the AMA in the case of Copeland versus Sullivan.

JEMPAC. Urged physicians to become familiar with views of local candidates and to support the efforts of JEMPAC.

AMA Delegation. Received a report from Joseph A. Riggs, MD, chairman, and Irving P. Ratner, MD, (*NJ MED* 89:643, 1992).

Council on Medical Services. Voted to refer the following recommendation to the Committee on Publication:

That the editor of *NEW JERSEY MEDICINE* be asked to devote a future issue to "Health Access New Jersey." Guest feature writers from other health care sectors, as well as legislators, would be invited to contribute articles representing a variety of perspectives.

Also, referred the following to the Council on Legislation for its review with appropriate representatives of the New Jersey Hospital Association:

That MSNJ support the proposed legislation entitled, "The Patient Protection in Utilization Review and Managed Care Act."

Also, approved the following recommendation:

That MSNJ support new programs to increase enrollment and graduates from instate facilities adequate to train physical therapists.

Noted, that MSNJ staff will research and confirm the validity of the following:

That MSNJ support the proposal that RNs and other trained professionals, e.g. exercise physiologists, be allowed to perform treatments such as diathermy, ultrasound, whirlpool, and exercises under appropriate supervision.

That MSNJ support the proposal that MDs, DOs, and DPMs be allowed to hire and direct physical therapy assistants.

Referred the following recommendation to the New Jersey Orthopaedic Society and the New Jersey Society of Physical Medicine and Rehabilitation for opinion and comment:

That MSNJ support the elimination of specific general education requirements for the licensing of foreign and out-of-state graduates.

Defeated the following recommendations:

That MSNJ embark on a program to certify anesthesia standards for free-standing surgical and procedural facilities in the state of New Jersey.

That the certification of free-standing surgical and procedural facilities in New Jersey be conducted in cooperation with appropriate specialty societies and other resources.

Council on Public Health.

1. Funding for Public Health Projects. Approved the following recommendation:

That MSNJ encourage the Legislature to assure an adequate level of funding for vital public health projects, including combating multiple drug resistant tuberculosis and the availability of medications for AIDS patients; and that the president convey MSNJ's concerns about public health funding to the appropriate leaders of the Legislature.

2. Clear Air—Rule Development Objectives. Approved the following recommendation:

That the Board of Trustees endorse the rule development objectives of the New Jersey State Department of Environmental Protection and Energy pertaining to the following aspects of clean air regulation: oxides of nitrogen; emissions statement; oxygenated fuel; emission offset; reasonably available control technology for volatile organic substances; operating permits; and vehicle inspections.

3. HIV/AIDS Issues. Approved the following recommendations:

That MSNJ oppose A-1027 and other proposed legislation establishing mandatory HIV testing for obtaining a marriage license.

That MSNJ support A-924, with reservations; and that the Special Committee on AIDS establish a subcommittee to develop a comprehensive proactive set of legislative recommendations including amendments to A-924 and new legislation.

That the president appoint a task force to cooperate with the New Jersey State Department of Health in developing guidelines for the practice of HIV-positive physicians in response to requirements of the Centers for Disease Control.

Committee on Utilization Review Systems. Approved the recommendation and agreed to initiate cooperation with this project:

That MSNJ and the New Jersey Hospital Association issue a joint statement of support for the Cooperative Cardiovascular Project.

Committee on Women in Medicine. Approved the following:

That MSNJ institute a series of annual leadership conferences on women in medicine, each featuring a different or discrete aspect of the challenges facing women physicians.

That the Committee on Women in Medicine plan to sponsor a leadership conference for women in medicine, emphasizing oral presentation skills involved in public speaking, media interviews, and academic seminars, to be held on September 30, 1992, at the executive offices in Lawrenceville.

That the Board of Trustees endorse the plans of the Committee on Women in Medicine to conduct a statewide Women's Health Conference on March 10, 1993.

Unfinished Business.

1. Proposed Changes in Dues Structure. Noted that the following recommendation would require a change in the bylaws; requested Committee on Revision of Constitution and Bylaws to develop a proposed amendment for consideration by the 1993 House of Delegates:

That the first full year of full membership be assessed at the rate of 50 percent of regular dues.

Agreed that the following can be accommodated under current policy applicable to financial hardship; county societies will be notified:

That any physician employed and/or practicing less than 20 hours per week, by request, may be assessed at the rate of 50 percent of regular dues.

That there be a waiver of dues assessment for a year of maternity leave, if so requested.

Referred the following to the AMA delegation for preparation of a resolution for submission to the 1992 AMA Interim Meeting:

That the AMA Delegation be requested to recommend similar policies be adopted for AMA membership. □

MSNJ AUXILIARY

On June 1, a leadership workshop was presented by Consensus Management Group, a New York consulting firm used by the AMA Auxiliary and various state medical societies. The purpose of the workshop was to assist MSNJ Auxiliary leaders in updating operations in the areas of administration, organization, and membership recruitment. The program was rated excellent by representatives from the 15 counties who attended. An informative session on parliamentary procedure and an "Idea Fair" on communications, membership development, AMA-ERF, and health promotions followed.

The Auxiliary's "Responsibility On Water" (ROW) campaign, designed to prevent injury and death by alerting young people to the risk of combining alcohol with water sports, is a success. Each county auxiliary, under the leadership of a county chairman, is promoting the ROW program including organizing and sponsoring regional educational programs in schools and at community health fairs; and implementing local public awareness at shore and lake resorts by using promotional materials like posters, buttons, bumper stickers, public service announcements, banner planes, boat parades, swimming races, and many other innovative public events. Details of the program may be found in the summer issue of *The Shingle.*

Nationally, delegates attending the AMA Auxiliary House of Delegates annual meeting in Chi-

cago voted to change the name from "Auxiliary" to "Alliance" and to add a tagline, "Physicians' spouses dedicated to the health of America." The change will become effective after the AMAA bylaws are revised in June 1993. The name applies only to the national organization, and does not affect state and county auxiliaries.

Finally, a major drive is underway to raise funds for the American Medical Association-Education and Research Foundation (AMA-ERF). Jeanne Leisner, AMA-ERF chairman, wrote the following letter:

The American Medical Association-Education and Research Foundation (AMA-ERF) was established 40 years ago by the AMA Board of Trustees to support medical education. AMA-ERF currently has several funds. The Medical School Excellence Fund provides grants to medical schools to use as they see fit. The Medical Student Assistance Fund provides grants to medical schools for student financial aid. The Development Fund is used at the discretion of the AMA-ERF Board of Directors to support pilot and experimental health and medical programs and the Categorical Fund is used for specific research areas.

The national, state, and county auxiliary AMA-ERF committee members who work so hard for the foundation never forget why they do it: Because funds must be available if the tradition of quality health care is to continue. Giving to and through AMA-ERF helps achieve that goal by maximizing individual contributions, ensuring accountability, promoting visibility, and motivating and encouraging support. Every time physicians contribute to medical schools, they demonstrate the medical community's commitment to leaving a legacy of quality health and medical care for future generations of Americans.

The next time you are preparing to contribute to your alma mater, please take the time to fill out an AMA-ERF card so your donation can be made through AMA-ERF. The future of medicine depends on it. □ Marion H. Geib

UMDNJ NOTES

UMDNJ Flexibility Act. Governor Jim Florio signed into law the University of Medicine and Dentistry of New Jersey Flexibility Act of 1992, calling it "a powerful catalyst for growth that will help meet the challenges of the global marketplace."

At the signing, Governor Florio said: "This bill puts UMDNJ on equal footing with the health sciences universities in other states when it comes to capturing research dollars. This gives New Jersey the same ability to fuse the highest academic talents with corporate financial backing that we see in countries like Japan and Germany, where government and industry work as partners. Those public-private partnerships will fuel the new business ventures of the 21st century and keep health care and pharmaceutical jobs here in New Jersey."

Senator Matthew Feldman (D-Bergen) sponsored the bill in the Senate and Assemblyman John A. Rocco (R-Camden) sponsored the legislation in the Assembly.

UMDNJ's flexibility legislation made several changes in the laws applying to the operation of the school. Through these changes, or amendments, the UMDNJ Board of Trustees gained authorization to create separate corporations to form joint ventures with private industry. The new law, which seeks no additional state funding for UMDNJ, acknowledges UMDNJ's broad role in health sciences education and, in general, increases UMDNJ's operating flexibility.

Mrs. Florio encourages minority students. New Jersey's First Lady Lucinda Florio encouraged the 25 participants in the Minority High School Student Research Apprentice program to continue their pursuit of unique learning experiences. "This is one of the most successful and innovative education programs anywhere in the country because all of you come determined to achieve your very best," she told the students at a closing ceremony of the summer program at UMDNJ-Robert Wood Johnson Medical School.

The apprenticeship program, funded by a grant from the National Institutes of Health, was created in 1981 to stimulate interest among minority high school students in biomedical research and health professions. The students, who attend high schools in central and southern New Jersey, were recommended for the program by their science teachers. Final selection was made by an admissions committee. Four high school science teachers assisted UMDNJ faculty members with research projects.

Nondrug ways to control hypertension in elderly. Researchers at UMDNJ-Robert Wood Johnson Medical School have launched a four-year $2.68 million study to demonstrate that losing weight and reducing salt can replace drugs to control blood pressure in people aged 65 to 80.

The four-center investigation, funded by the National Institutes of Health, is the first large-scale study designed to take elderly patients off the medications that have controlled their hypertension.

Dr. John Kostis, chairman of the Department of Medicine at the medical school, is directing the study. The other centers are Johns Hopkins Medical School, Baltimore, Maryland; Bowman Gray School of Medicine, Winston-Salem, North Carolina; and the University of Tennessee, Memphis.

Cystic fibrosis patients test new drug. A new drug that may advance the treatment of cystic fibrosis (CF) is being tested at UMDNJ-New Jersey Medical

School. The drug, a diuretic called Amiloride,® is expected to reduce the thickness and stickiness of the mucus found in the lungs of CF patients, making it easier for them to cough it up. Over a prolonged period, the drug may even prevent the sludge-like mucus from forming.

The clinical trial at UMDNJ, the only New Jersey site for the study and 1 of 14 nationwide sites, will determine whether this drug slows lung deterioration in CF patients, affects their quality of life, or has any long-term side effects. Dr. Nelson Turcios is principal investigator. ☐ Stanley S. Bergen, Jr, MD, President

AMNJ REPORT

The Academy of Medicine of New Jersey (AMNJ) is pleased to announce that again it is offering forums on biomedical ethics with the Citizen's Committee on Biomedical Ethics. AMNJ has been successfully cooperating with the Committee since 1987 and the new topics for the 1992-1993 year include: "Patients, Providers, and Institutions: The Impact of Advance Directives on Medical Decision Making"; "Physician-Assisted Suicide: The Responsibilities of the Doctor in Caring for Terminally Ill Patients"; "Ethics Committees and Health Care Decision Making: The Impact of the Ethics Consultation on the Physician"; "The Distribution of Our Resources: What Role Should Physicians Play?"; and "New Business for Ethics Committees: Economic Issues and Their Impact on Physicians and Patients."

These topics are of particular interest at this time, however, topics that meet the needs of individual medical groups can be arranged. We have made the offering to specialty societies, county medical societies and New Jersey hospitals.

The Sixth Annual Governor's Jersey Pride Awards Program will culminate on November 20, 1992, with the presentation of 14 awards to distinguished New Jerseyans. The Governor's Awards Ceremony will take place at 6:30 P.M. at the State Street Theatre in New Brunswick. AMNJ and the American Red Cross are responsible for recommending nominees for the Clara Barton Medical Service Award.

The Seventeenth Annual New Jersey Orthopaedic Symposium, cosponsored by AMNJ and the New Jersey Orthopaedic Society, will be held on October 23-24, 1992, at the Somerset Marriott Hotel in Somerset. Dr. Marc Malberg, program chairman, and Dr. Robert Grossman, program secretary, have arranged an outstanding program. The Complications/Residents' Thesis Conference will be held on Friday from 2:00-5:45 P.M. and members are encouraged to bring cases and complications for presentation. A cocktail party and dinner will follow at 6:00 P.M. including an after-dinner speaker.

The all-day program on Saturday will feature: Dr. Keith Bridwell of Washington University Medical Center in St. Louis; Dr. John Frymoyer of the University of Vermont College of Medicine; Dr. E. Shannon Stouffer of Southern Illinois University School of Medicine; Dr. Arthur White of the SpineCare Medical Group, Daly City, California; and Dr. Hansen Yuan of the State University of New York, Syracuse.

The Symposium is designed to provide an opportunity for orthopaedists in the tri-state area to hear timely topics of current interest presented by national leaders in various fields.

AMNJ and the UMDNJ-COPSA Institute for Alzheimer's Disease and Related Disorders are sponsoring "Mental Disorders in the Elderly: Confronting the 21st Century" on October 23, 1992, at the Hyatt Regency Hotel in New Brunswick. This one-day symposium addresses the management of mental disorders in the elderly. This conference offers a better understanding of the features of mental illness in the elderly, addresses obstacles to care, and presents new approaches to diagnosis and treatment. ☐ George J. Hill, MD, President

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Early Diagnosis of Acute Myocardial Infarction

Moderator: Bernard L. Segal, M.D.

3:00-3:30	Common and uncommon presenting symptoms and signs—***Norman Feinsmith, M.D.***
3:30-4:00	Early management of acute myocardial infarction—***Bernard L. Segal, M.D.***
4:00-5:00	Case Presentations—***Stephen A. Roberts, M.D.*** Panel Discussion—***Norman Feinsmith, M.D., Kathleen Magness, M.D., Samuel Ruby, M.D.***

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CONTINUING EDUCATION

ANESTHESIOLOGY

November

11 **New Inhalation Anesthetics**
8-9 P.M.—West Jersey Hospital, Voorhees
(AMNJ)

17 **General Membership Meeting**
All day—Ramada Inn, Clark
(NJ State Society of Anesthesiologists)

DIABETES

November

2 **Diabetes in Pregnancy**
11:30 A.M.-12:30 P.M.—Columbus Hospital, Newark
(AMNJ and NJDOH)

11 **Prevention of Lower Extremity Amputations**
1-2 P.M.—VA Medical Center, Lyons
(AMNJ and NJDOH)

12 **Prevention of Lower Extremity Amputations**
2-3 P.M.—New Jersey Veterans Home, Paramus
(AMNJ)

18 **Diabetic Nephropathy**
8-9 A.M.—Somerset Medical Center, Somerville
(AMNJ and NJDOH)

December

3 **Diabetic Retinopathy**
2-3 P.M.—New Jersey Veterans Home, Paramus
(AMNJ and NJDOH)

9 **Diabetes-Related Cardiovascular Disease**
11:30 A.M.-12:30 P.M.—Rahway Hospital, Rahway
(AMNJ and NJDOH)

9 **Diabetic Nephropathy**
1-2 P.M.—VA Medical Center, Lyons
(AMNJ and NJDOH)

INFECTIOUS DISEASE

November

4 **Integrating TB Management into Care of the HIV-Infected Patient**
9-10 A.M.—Elizabeth General Medical Center, Elizabeth
(NJDOH and AMNJ)

4 **Integrating TB Management into Care of the HIV-Infected Patient**
12 Noon-1 P.M.—Southern Ocean County Hospital, Manahawkin
(NJDOH and AMNJ)

11 **Infection Control in the HIV Era**
8-9 A.M.—Somerset Medical Center, Somerville
(AMNJ and NJDOH)

12 **Infection Control in the HIV Era**
10-11 A.M.—Scanticon-Forrestal Center, Princeton
(AMNJ and NJDOH)

17 **Identification and Management of Asymptomatic HIV Infection**
1:30-2:30 P.M.—Kimball Medical Center, Lakewood
(AMNJ and NJDOH)

18 **Identification and Management of Asymptomatic HIV Infection**
10-11 A.M.—The Hospital Center at Orange, Orange
(NJDOH and AMNJ)

18 **Diagnosis and Treatment of AIDS**
6-7 P.M.—Rancocas Hospital, Willingboro
(AMNJ)

December

2 **Diagnosis and Treatment of AIDS**
11 A.M.-12 Noon—Kessler Memorial Hospital, Hammonton
(AMNJ and NJDOH)

2 **Infection Control in the HIV Era**
1:30-2:30 P.M.—Runnells Specialized Hospital, Berkeley Heights
(AMNJ and NJDOH)

4 **Identification and Management of Asymptomatic HIV Infection**
10-11 A.M.—Marlboro Psychiatric Hospital, Marlboro
(NJDOH and AMNJ)

9 **Integrating TB Management into Care of the HIV-Infected Patient**
12:30-1:30 P.M.—Kessler Institute for Rehabilitation, West Orange
(NJDOH and AMNJ)

9 **Diagnosis and Treatment of AIDS**
8-9 A.M.—Somerset Medical Center, Somerville
(AMNJ and NJDOH)

16 **Integrating TB Management into Care of the HIV-Infected Patient**
10-11 A.M.—The Hospital Center at Orange, Orange
(NJDOH and AMNJ)

16 **Identification and Management of Asymptomatic HIV Infection**
6-7 P.M.—Rancocas Hospital, Willingboro
(NJDOH and AMNJ)

18 **Integrating TB Management into Care of the HIV-Infected Patient**
12 Noon-1 P.M.—South Jersey Hospital System, Bridgeton
(AMNJ and NJDOH)

MEDICINE

November

3 **Thyroid Diseases**
12 Noon-1 P.M.—The Hospital Center at Orange, Orange
(AMNJ)

3-7 **32nd Annual Course in Clinical and Histopathologic Overview of Obstetrics/Gynecology**

Acupuncture & Electro-Therapeutics in Clinical Practice

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These meetings are co-sponsored by the International College of Acupuncture & Electro-Therapeutics & its official journal, Acupuncture & Electro-Therapeutics Research, The International Journal (published by Pergamon Press & indexed in 15 major indexing periodicals, including Index Medicus), Heart Disease Research Foundation; NY Pain Center; Electrical Engineering Dept., Manhattan College; Nordic Medical Acupuncture Society (Scandinavia); Schmerz Therapeutische Kolloquium (West Germany); Japan Bi-Digital O-Ring Test Assn.; Accredited toward Acupuncture Certification to practice acupuncture. Eligible for AMA CME Cat. I credit (about 40 credit-hours for the Symposium).

For information on meetings or submission or presentations of papers, contact Symposium Chairman, Prof. Y. Omura, M.D., Sc.D., 800 Riverside Drive (8-I) New York, NY 10032 Tel: (212) 781-6262 (10 am to 10 pm 7 days a week) or (212) 928-0658, Co-chairman, Prof. A.W. Cook, MD (516) 877-1821, or Bro. Michael Losco (212) 920-0162.

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For further information, please contact: Maryanne Basileo, Cooper Hospital/University Medical Center, Department of Surgery, Three Cooper Plaza, Suite 411, Camden, NJ 08103 or telephone (609) 342-3334.

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PRESENTS

9TH ANNUAL CLINICAL UPDATE IN PULMONARY MEDICINE

November 21, 1992 - Trump Regency - Atlantic City, New Jersey

designed for Family Practitioners, Internists, Pulmonologists and Allied Health Care Professionals
7 Hours Category 1 CME Credit - Optional Activity

PROGRAM

The New NHLBI Guidelines in Asthma Management	Roger C. Bone, MD
Hypoxemic Respiratory Failure	Neil R. MacIntyre, MD
ARDS and Multi-Organ Failure: A Current Perspective	Roger C. Bone, MD
Modern Mechanical Ventilation: A Practical Approach	Neil R. MacIntyre, MD
Lung Transplantation: Recipient Selection and Expectations	David M. F. Murphy, MD
The Clara Falk Franks Lecture - Tuberculosis: Update 1992	Henry Masur, MD
Lung Cancer: When Is It Malpractice to Fail to Diagnose?	E. James Potchen, MD
Life-Threatening Pulmonary Infections: Diagnosis and Antibiotic Selection	Henry Masur, MD
Diffuse Lung Disease: Pearls & Pitfalls	Mervyn Felerstein, MD

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8 A.M.-5 P.M.—The New York Hilton, New York
(Saint Barnabas Medical Center)

4 **Treatment of Acute Deep Venous Thrombosis**
6:30-10 P.M.—The Manor, West Orange
(AMNJ and Vascular Soc. of NJ)

4 **Stress and Disease**
12:15-2:30 P.M.—John Fitch Plaza, Trenton
(AMNJ and NJDOH)

5, 12, 19, 26 **Current Concepts in Medicine and Surgery**
11:45 A.M.—JFK Medical Center, Edison
(JFK Medical Center)

5 **Robert Wood Johnson Medical School Dermatological Special Conference**
6-9 P.M.—Rutgers Community Health Plan, 57 U.S. Highway 1, South, New Brunswick
(UMDNJ, Division of Dermatology)

6, 20 **Grand Rounds**
9-10 A.M.—St. Francis Medical Center, Trenton
(St. Francis Medical Center)

6 **Hepatitis**
10:30-11:30 A.M.—Marlboro Psychiatric Hospital, Marlboro
(AMNJ)

9 **Malpractice, Risk Prevention**
7-8 P.M.—Wallkill Valley General Hospital, Sussex
(AMNJ)

10 **Interpretation of Diagnostic Laboratory Studies in Anemia, Hepatic Disorder, and Lipid Metabolism Disorders**
1:30-2:30 P.M.—Greystone Park Psychiatric Hospital, Greystone Park
(AMNJ and Greystone Park Psychiatric Hospital)

10 **General Dermatology Membership Meeting**
6 P.M.—Schering Corporation, Kenilworth
(Dermatological Society of NJ)

13-14 **Enhancing Team Performance: A Clinical Reasoning Institute**
8 A.M.-5 P.M.—Kessler Conference Center, West Orange
(Kessler Institute)

18 **New Practice Program**
8:45 A.M.-4 P.M.—MSNJ headquarters, Lawrenceville
(MIIX and AMNJ)

19 **Emergency Treatment of Paroxysmal Supraventricular Tachycardia**
5-6 P.M.—Somerset Medical Center, Somerville
(Somerset Medical Center)

19 **Acute Respiratory Failure**
12 Noon-1 P.M.—Helene Fuld Medical Center, Trenton
(Helene Fuld Medical Center)

21 **Pathology Slide Show**
9 A.M.-4 P.M.—Robert Wood Johnson Medical School, Piscataway
(NJ Society of Pathologists and AMNJ)

December

1 **Acute Renal Failure**
12 Noon-1 P.M.—The Hospital Center at Orange, Orange
(AMNJ)

2 **Pediatric Society Meeting**
8:30 A.M.-4 P.M.—Sheraton Hotel, Woodbridge
(AMNJ and NJ Pediatric Society)

2 **Medical Problems in the Elderly**
8-9 A.M.—Somerset Medical Center, Somerville
(AMNJ and NJDOH)

2 **Child Sexual Abuse and Neglect**
9-10 A.M.—Riverview Medical Center, Red Bank
(AMNJ)

3, 10, 17 **Current Concepts in Medicine and Surgery**
11:45 A.M.—JFK Medical Center, Edison
(JFK Medical Center)

4 **Geriatrics: Camouflaged Medical Illness**
10:30-11:30 A.M.—Marlboro Psychiatric Hospital, Marlboro
(AMNJ)

4, 18 **Grand Rounds**
9-10 A.M.—St. Francis Medical Center, Trenton
(St. Francis Medical Center)

10 **Obsessive Compulsive Disorder**
5-6 P.M.—Somerset Medical Center, Somerville
(Somerset Medical Center)

11 **Addressing Nicotine Dependence in the 1990s**
8:30 A.M.-4:30 P.M.—The Hyatt Regency, New Brunswick
(AMNJ and MSNJ)

14 **Aspirations Syndrome in the Mentally Retarded**
1-2 P.M.—New Lisbon Developmental Center, New Lisbon
(AMNJ)

16 **Medical Problems in the Elderly**
11:30 A.M.-12:30 P.M.—Rahway Hospital, Rahway
(AMNJ and NJDOH)

17 **Critical Care—ICU Priorities**
12 Noon-1 P.M.—Helene Fuld Medical Center, Trenton
(Helene Fuld Medical Center)

18 **Parkinsonism**
10:30-11:30 A.M.—Marlboro Psychiatric Hospital, Marlboro
(AMNJ)

ONCOLOGY AND RADIATION ONCOLOGY

November

18 **Scientific Meeting**
6:30-9:30 P.M.—The Manor, West Orange
(Radiation Oncology Section, AMNJ)

December

2 **Statewide Tumor Board Conference**
6-9 P.M.—The Hyatt Regency, New Brunswick
(Oncology Society of NJ, AMNJ)

3 **Scientific Meeting**
6:30-9:30 P.M.—The Nassau Inn, Princeton
(Head and Neck Oncology Section, AMNJ)

PSYCHIATRY

November

4 **Psychiatric Case Conference**
1:30-2:30 P.M.—Greystone Park Psychiatric Hospital, Greystone Park
(AMNJ)

12 **Monthly Meeting**
6 P.M.—Hackensack Medical Center, Hackensack
(NJ Psychoanalytic Society and AMNJ)

18 **Journal Club**

Hahnemann University

Department of Medicine Grand Rounds
Wednesdays 8:30 a.m.-9:30 a.m.

OCTOBER 1992

October 7, 1992
Yom Kippur—No Grand Rounds

October 14, 1992
MECHANISMS OF GUT PEPTIDES IN NEUROENDOCRINE DISORDERS
Thomas O'Dorisio, M.D.
Professor of Medicine and Physiology
Director, Division of Endocrinology
Ohio State University
Columbus, Ohio

October 21, 1992
PULMONARY DISEASE
Jay N. Nadel, M.D.
Professor of Medicine and Physiology
Chief, Section of Pulmonary Diseases
Director, Multidisciplinary Training Program in Lung Diseases, C.V.R.I.
University of California/San Francisco
San Francisco, CA

October 28, 1992
NEW APPROACHES TO IDENTIFICATION OF MYOCARDIAL ISCHEMIA
Leonard S. Dreifus, M.D.
Professor of Medicine
Director, Division of Cardiovascular Diseases
Hahnemann University
J. Yasha Kresh, Ph.D.
Professor of Medicine
Director of Cardiothoracic Surgical Research and Director of Cardiovascular Biophysics and Computing
Division of Cardiovascular Diseases
Hahnemann University
Amir Pelleg, Ph.D.
Professor of Medicine
Division of Cardiovascular Diseases
Hahnemann University

NOVEMBER 1992

November 4, 1992
HYPOTHYROIDISM: PATHOGENESIS AND IMMUNE MECHANISMS
E. Chester Ridgway, III, M.D.
Professor of Medicine
Head, Division of Endocrinology
University of Colorado Health Science Center
Denver, CO

November 11, 1992
LV REMODELING: CELLULAR AND THERAPEUTIC CONSIDERATIONS
Gary S. Francis, M.D.
Professor of Medicine
Cardiovascular Division
University of Minnesota School of Medicine
Minneapolis, MN

November 18, 1992
MECHANISMS AND NEW STRATEGIES FOR TREATING AUTOIMMUNE DISEASES
David Wofsy, M.D.
Associate Professor of Medicine
Chief, Rheumatology Division
San Francisco VA Medical Center
San Francisco, CA

November 25, 1992
Thanksgiving Holiday—No Grand Rounds

DECEMBER 1992

December 2, 1992
ASTHMA BY INGESTION: ASPIRIN, SULFITE, M.S.G. AND TARTRAZINE SENSITIVITY
Ronald Simon, M.D.
Associate Clinical Professor of Medicine & Pediatrics
University of California/San Diego School of Medicine
Head, Division of Allergy & Clinical Immunology
Scripps Clinic and Research Foundation
La Jolla, CA

December 9, 1992
CHOLESTEROL REDUCTION IN PRIMARY PREVENTION: UNANSWERED QUESTIONS AND UNQUESTIONED ANSWERS
Jeremy Swan, M.D., Ph.D.
Professor of Medicine
UCLA School of Medicine
Los Angeles, CA

December 16, 1992
BREAST CANCER: DIAGNOSIS AND TREATMENT
Michael P. Moore, M.D., Ph.D.
Assistant Professor of Surgery
Cornell University School of Medicine
Sloan-Kettering Cancer Center
New York, NY

December 23, 1992
Christmas Holidays—No Grand Rounds

Hahnemann University Department of Medicine
Wednesday Medical Seminar Series
8:30 a.m.—3:30 p.m.

October 21, 1992
PULMONARY MEDICINE
Course Director: Edward S. Schulman, M.D.
Guest Faculty: Jay A. Nadal, M.D.

November 18, 1992
MECHANISMS AND STRATEGIES FOR TREATING AUTOIMMUNE DISEASES
Course Director: Richard L. Spielvogel, M.D.
Guest Faculty: Alice Gottlieb, M.D.
Richard P. MacDermott, M.D.
David Wofsy, M.D.

December 2, 1992
ASTHMA
Course Directors: David M. Lang, M.D.
Guest Faculty: Ronald Simon, M.D.

December 16, 1992
BREAST CANCER: DIAGNOSIS AND TREATMENT
Course Codirectors: Jeffrey Brodsky, M.D.
Pamela Crilley, D.O.
Guest Faculty: Michael P. Moore, M.D., Ph.D.

Seminar Director:

Allan B. Schwartz, M.D.
Professor and Vice Chairman of Medicine
Director, Continuing Medical Education for the Department of Medicine

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2:30-4 P.M.—Greystone Park Psychiatric Hospital, Greystone Park
(AMNJ)

20 Medication Interactions
10:30-11:30 A.M.—Marlboro Psychiatric Hospital, Marlboro
(AMNJ)

December

2 Psychiatric Case Conference
1:30-2:30 P.M.—Greystone Park Psychiatric Hospital, Greystone Park
(AMNJ)

9 Post-traumatic Stress Disorders
1:30-2:30 P.M.—Greystone Park Psychiatric Hospital
(AMNJ)

16 Journal Club
2:30-4 P.M.—Greystone Park Psychiatric Hospital, Greystone Park
(AMNJ)

RADIOLOGY

November

19 Joint Scientific Meeting: Radiological Society of NJ and NJ Institute of Ultrasound in Medicine, Diagnostic Radiology Section
7:30-10 P.M.—Saint Barnabas Medical Center, Livingston
(AMNJ)

December

15 Scientific Meeting
7:30-10 P.M.—Saint Barnabas Medical Center, Livingston
(Radiological Society of NJ and Diagnostic Radiology Section)

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IN MEMORIAM

STUART M. APPLEBAUM

We regret to inform you of the death of Stuart Mark Applebaum, MD, on June 7, 1992. Dr. Applebaum was a urologist. He was born on November 14, 1949, and was awarded a medical degree from the College of Medicine and Dentistry, Newark, in 1975. Dr. Applebaum completed a residency at Montefiore Hospital and at New York University Medical Center, both in New York. Dr. Applebaum maintained practices in Morristown and Chester and was affiliated with Dover General Hospital and Medical Center; Morristown Memorial Hospital; United Hospitals Medical Center, Newark; and St. Clare's Riverside Medical Center, Denville. Dr. Applebaum was a member of our Morris County component, a diplomate of the American Board of Urology, and a fellow of the American College of Surgeons.

MICHAEL P. CERCHIO

Seventy-six-year old Michael Patrick Cerchio, MD, died on June 21, 1992; he was born in Jersey City on June 19, 1916. A 1943 graduate of Creighton University School of Medicine, Omaha, Nebraska, Dr. Cerchio completed an internship at St. Mary Hospital, Hoboken. He maintained a general practice in Jersey City for 40 years, and was affiliated with St. Francis Hospital, St. Mary Hospital, and Jersey City Medical Center. Dr. Cerchio also was the deputy chief medical examiner for Hudson County. Dr. Cerchio served in the United States Army during World War II.

HENRY E. HARRIS

Neurologist Henry E. Harris, MD, passed away on May 25, 1992. He was born in New York City in 1930. After serving in the United States Army, Dr. Harris earned a medical degree from Howard University College of Medicine, Washington, DC, in 1959; he completed an internship at United States Public Health Service (USPHS) Hospital, Staten Island, and a residency at USPHS Hospital and at Mt. Sinai Hospital, New York. Dr. Harris received his license to practice medicine in New York in 1964 and in New Jersey in 1969. Dr. Harris maintained offices in Orange and East Orange. During his medical career, Dr. Harris was chief of neurology at East Orange General Hospital from 1979 to 1981; chairman of the neurology department at The Hospital Center at Orange from 1981 to 1984; and assistant clinical professor at UMDNJ, Newark. From 1959 to 1969, Dr. Harris worked with USPHS, Marine Corps Hospital, Staten Island, as assistant medical officer and chief of neurology. Dr. Harris was affiliated with United Hospitals Medical Center, Newark; Saint Barnabas Medical Center, Livingston; St. Mary's Hospital, Orange; Newark Beth Israel Medical Center; and Irvington General Hospital. Dr. Harris was a member of our Essex County component, serving on the governing council; he was a trustee of the New Jersey Multiple Sclerosis Society and of the National Epilepsy Foundation.

EMANUEL LICCESE

Former chief of surgery at St. James Hospital, Newark, Emanuel Liccese, MD, died on June 26, 1992. Dr. Liccese was born on June 22, 1904, in Newark. He attended George Washington University School of Medicine, Washington, DC, and was awarded a medical degree in 1930. Dr. Liccese had a surgical practice in Newark, and was affiliated with St. James Hospital for 58 years. He also was on staff at Clara Maass Medical Center, Belleville, and Columbus Hospital, Newark City Hospital, Saint Michael's Medical Center, and United Hospitals Medical Center, all in Newark. In 1980, Dr. Liccese was awarded a distinguished service award from St. James Hospital. He was a member of our Essex County component and of the American Medical Association, and a fellow of the American College of Surgeons and of the International College of Surgeons. Dr. Liccese served in the United States Army Air Corps as a lieutenant colonel and director of surgery.

VINCENT P. MAHONEY

Born on November 15, 1914, in Connellsville, Pennsylvania, Vincent Paul Mahoney, MD, passed away on June 15, 1992. Dr. Mahoney attended the University of Pittsburgh School of Medicine, and was awarded a medical degree in 1938. Dr. Mahoney was a psychiatrist who practiced in Camden and was affiliated with Our Lady of Lourdes Hospital, Camden. He was a member of our Camden County component and of the American Medical Association, a fellow of the American Psychiatric Association, and a diplomate of the American Board of Psychiatry. Dr. Mahoney was a World War II United States Army veteran.

EDWARD I. PANZER

Middlesex County Medical Society member, Edward Isidor Panzer, MD, died on May 24, 1992. Dr. Panzer, born in Poland on June 9, 1912, was awarded a medical degree from the Faculty of Medicine University of Palermo, Italy, in 1937. Prior to coming to the United States, Dr. Panzer practiced in Europe from 1937 to 1945. Dr. Panzer received licenses to practice medicine in New Jersey, New York, and Ohio. He completed an internship at Bayonne Hospital and Dispensary in 1948. A psychiatrist, Dr. Panzer was affiliated with the New Jersey State Hospital, Greystone Park and Marlboro, the VA Hospital, New York, and South Amboy Memorial Hospital. His medical career also included directorship of the Middlesex County Medical Health Clinic. Dr. Panzer maintained a private practice in New Brunswick. He was a diplomate of the American Board of Psychiatry, and a fellow of the American Psychiatric Association.

DONALD F. SHIELDS

Born in Paterson on March 16, 1932, Donald Finch Shields, MD, died on March 31, 1992. Dr. Shields was awarded a medical degree from the State University College of Medicine, New York, in 1957. He completed an internship at the former Orange Memorial Hospital, in 1958, and a residency at Orange Memorial Hospital in 1961, and at Memorial Hospital, New York, in 1962. Dr. Shields received his New Jersey medical license in 1958. He was associate director at Hackensack Hospital from 1963 to 1967; pathologist at Valley Hospital, Ridgewood and at Point Pleasant Hospital; and director at Point Pleasant Hospital and Brick

Hospital. Dr. Shields was a member of our Essex and Ocean County components; a fellow of the American College of Physicians; and a diplomate of the American Board of Clinical Pathology and Pathologic Anatomy. Dr. Shields resided in Upper Saddle River and Manasquan.

GEORGE P. SNYDER

A World War II United States Army veteran, George Peter Snyder, MD, passed away on May 29, 1992. He was 76 years old. Dr. Snyder was born in 1915, and he earned a medical degree from the University of Southern California, Los Angeles, in 1947. Dr. Snyder was on staff at Holy Name Hospital, Teaneck, for 30 years. He was a family practitioner and was a member of our Bergen County component and of the American Medical Association. Dr. Snyder resided in River Edge and Oradell, and retired to Lakeland, Florida.

NICHOLAS B. SPORTELLI

At the untimely age of 53, Brick Township resident Nicholas B. Sportelli, MD, passed away on March 16, 1992. He was born on April 2, 1938, in New York City. Dr. Sportelli attended the University of Bologna Medical School, Italy, and was awarded his medical degree in 1967. Dr. Sportelli received his Pennsylvania and New Jersey medical licenses in 1971 and 1974, respectively. He served an internship at Nassau Hospital, New York, and a residency at Queens General Hospital, New York. He completed a fellowship at Queens General Hospital, New York. Dr. Sportelli practiced in Bricktown and was attending at Point Pleasant Hospital and Kimball Medical Center, Lakewood. Dr. Sportelli, a gynecologist and obstetrician, was a member of our Ocean County component.

ALAN J. STOLOW

A specialist in chest diseases, Alan J. Stolow, MD, died on January 14, 1992. Dr. Stolow practiced in Somerville. He was affiliated with The Medical Center at Princeton; Warren Hospital, Phillipsburg; and Somerset Medical Center, Somerville. Dr. Stolow was a member of our Somerset County component and of the American Medical Association, and a fellow of the American College of Chest Physicians. Dr. Stolow retired to San Mateo, California.

WALTER VAN NESS

Past president of the Bloomfield Board of Health, Walter Van Ness, MD, died on May 16, 1992. Born in Paterson in 1916, Dr. Van Ness received his medical degree from New York University College of Medicine, New York, in 1944. He completed an internship at Newark City Hospital and a residency in general surgery at the former Harrison S. Martland Memorial Center, Newark. Dr. Van Ness maintained a private practice in Bloomfield for 45 years, and was affiliated with The Mountainside Hospital, Montclair, and Presbyterian Hospital, Newark. He was a member of our Essex County component and of the American Medical Association. Dr. Van Ness served as a captain in World War II, in the Philippines and in Korea.

EDITORIAL CRITERIA

CONTENT

NEW JERSEY MEDICINE is the official organ of the Medical Society of New Jersey. The goals are educational and informational. All material published is copyrighted by the Medical Society of New Jersey.

The educational contents of each issue appear as scientific articles, based on research, original concepts relative to epidemiology of disease, and treatment methodology; case reports; review articles; clinical notes; state of the art reports; and special articles, that include evaluations, policy and position papers, and reviews of nonscientific subjects. Other topics include professional liability commentary; critical narration; medical history; pediatric briefs; nutrition update; and opinions. Editorials are prepared by the editor and by guest contributors on timely and relevant subjects. The Doctors' Notebook section contains organizational and administrative items from the Medical Society of New Jersey and from the community. Letters to the editor and book reviews are welcome and will be published as space permits.

The principal aim in the preparation of a contribution should be relevance to diagnosis and treatment and to the education of patients and professionals. Preference will be given to authors from New Jersey and to out-of-state lecturers submitting a suitable manuscript based on a presentation made to an audience in New Jersey.

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Submit two manuscripts that must be typewritten and double spaced on 8½" by 11" paper. Statistical methods used in articles should be identified.

The title page should include the full name, degrees, and affiliations of all authors, and the name and address of the author to whom reprint requests and correspondence should be sent.

The author should submit a 30-word abstract to be used at the beginning of the article.

Tables must be typewritten and double spaced on separate 8½" by 11" sheets, with a title and number. Symbols for units should be confined to column headings, and abbreviations should be kept to a minimum.

Illustrations should be professional quality, black-and-white glossy prints. The name of the author, figure number, and the top of the figure should be noted on a label attached to the back of each illustration. When photographs of patients are used, the subjects should not be identifiable or publication permission, signed by the subject or responsible person, must be included with the photograph. Material taken from other publications must give credit to the source.

Generic names should be used with proprietary names indicated parenthetically or as a footnote with the first use of the generic name. Proprietary names of devices should be indicated by the registration symbol—®.

The summary of the article should not exceed 250 words; it should contain essential facts.

References should not exceed 35 citations except in review articles, and should be cited consecutively by numbers in parentheses at the end of the sentence. The style of *NEW JERSEY MEDICINE* is that of *Index Medicus:*

1. Goldwyn RM: Subcutaneous mastectomy. *NJ MED* 74:1050-1052, 1977.

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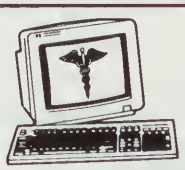
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(ranitidine hydrochloride)

BRIEF SUMMARY

The following is a brief summary only. Before prescribing, see complete prescribing information in Zantac® product labeling.

INDICATIONS AND USAGE: Zantac® is indicated in:
1. Short-term treatment of **active duodenal ulcer.** Most patients heal within 4 weeks.
2. **Maintenance therapy** for duodenal ulcer patients at reduced dosage after healing of acute ulcers.
3. The treatment of **pathological hypersecretory conditions** (e.g., Zollinger-Ellison syndrome and systemic mastocytosis).
4. Short-term treatment of **active, benign gastric ulcer.** Most patients heal within 6 weeks and the usefulness of further treatment has not been demonstrated.
5. Treatment of **gastroesophageal reflux disease (GERD).** Symptomatic relief commonly occurs within 1 or 2 weeks after starting therapy with Zantac 150 mg b.i.d.
6. Treatment of endoscopically diagnosed **erosive esophagitis.** Healing of endoscopically diagnosed erosive esophagitis occurs at 4 weeks (47%), 8 weeks (71%), and 12 weeks (84%) of therapy with Zantac 150 mg q.i.d. Symptomatic relief of heartburn commonly occurs within 24 hours of therapy initiation with Zantac.

Concomitant antacids should be given as needed for pain relief to patients with active duodenal ulcer; active, benign gastric ulcer; hypersecretory states; GERD; and erosive esophagitis.

CONTRAINDICATIONS: Zantac® is contraindicated for patients known to have hypersensitivity to the drug.

PRECAUTIONS: General: 1. Symptomatic response to Zantac® therapy does not preclude the presence of gastric malignancy.
2. Since Zantac is excreted primarily by the kidney, dosage should be adjusted in patients with impaired renal function (see DOSAGE AND ADMINISTRATION). Caution should be observed in patients with hepatic dysfunction since Zantac is metabolized in the liver.
Laboratory Tests: False-positive tests for urine protein with Multistix® may occur during Zantac therapy, and therefore testing with sulfosalicylic acid is recommended.
Drug Interactions: Although Zantac has been reported to bind weakly to cytochrome P-450 *in vitro,* recommended doses of the drug do not inhibit the action of the cytochrome P-450-linked oxygenase enzymes in the liver. However, there have been isolated reports of drug interactions that suggest that Zantac may affect the bioavailability of certain drugs by some mechanism as yet unidentified (e.g., a pH-dependent effect on absorption or a change in volume of distribution).

Increased or decreased prothrombin times have been reported during concurrent use of ranitidine and warfarin. However, in human pharmacokinetic studies with dosages of ranitidine up to 400 mg per day, no interaction occurred; ranitidine had no effect on warfarin clearance or prothrombin time. The possibility of an interaction with warfarin at dosages of ranitidine higher than 400 mg per day has not been investigated.
Carcinogenesis, Mutagenesis, Impairment of Fertility: There was no indication of tumorigenic or carcinogenic effects in life-span studies in mice and rats at dosages up to 2,000 mg/kg per day.

Ranitidine was not mutagenic in standard bacterial tests (*Salmonella, Escherichia coli*) for mutagenicity at concentrations up to the maximum recommended for these assays.

In a dominant lethal assay, a single oral dose of 1,000 mg/kg to male rats was without effect on the outcome of two matings per week for the next 9 weeks.
Pregnancy: ***Teratogenic Effects: Pregnancy Category B:*** Reproduction studies have been performed in rats and rabbits at doses up to 160 times the human dose and have revealed no evidence of impaired fertility or harm to the fetus due to Zantac. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.
Nursing Mothers: Zantac is secreted in human milk. Caution should be exercised when Zantac is administered to a nursing mother.
Pediatric Use: Safety and effectiveness in children have not been established.
Use in Elderly Patients: Ulcer healing rates in elderly patients (65-82 years of age) were no different from those in younger age-groups. The incidence rates for adverse events and laboratory abnormalities were also not different from those seen in other age-groups.

ADVERSE REACTIONS: The following have been reported as events in clinical trials or in the routine management of patients treated with Zantac®. The relationship to Zantac therapy has been unclear in many cases. Headache, sometimes severe, seems to be related to Zantac administration.
Central Nervous System: Rarely, malaise, dizziness, somnolence, insomnia, and vertigo. Rare cases of reversible mental confusion, agitation, depression, and hallucinations have been reported, predominantly in severely ill elderly patients. Rare cases of reversible blurred vision suggestive of a change in accommodation have been reported. Rare reports of reversible involuntary motor disturbances have been received.
Cardiovascular: As with other H_2-blockers, rare reports of arrhythmias such as tachycardia, bradycardia, atrioventricular block, and premature ventricular beats.
Gastrointestinal: Constipation, diarrhea, nausea/vomiting, abdominal discomfort/pain, and rare reports of pancreatitis.
Hepatic: In normal volunteers, SGPT values were increased to at least twice the pretreatment levels in 6 of 12 subjects receiving 100 mg q.i.d. intravenously for 7 days, and in 4 of 24 subjects receiving 50 mg q.i.d. intravenously for 5 days. There have been occasional reports of hepatitis, hepatocellular or hepatocanalicular or mixed, with or without jaundice. In such circumstances, ranitidine should be immediately discontinued. These events are usually reversible, but in exceedingly rare circumstances death has occurred.

Zantac® 150 and 300 (ranitidine hydrochloride) Tablets
Zantac® (ranitidine hydrochloride) Syrup

Musculoskeletal: Rare reports of arthralgias.
Hematologic: Blood count changes (leukopenia, granulocytopenia, and thrombocytopenia) have occurred in a few patients. These were usually reversible. Rare cases of agranulocytosis, pancytopenia, sometimes with marrow hypoplasia, and aplastic anemia and exceedingly rare cases of acquired immune hemolytic anemia have been reported.
Endocrine: Controlled studies in animals and man have shown no stimulation of any pituitary hormone by Zantac and no antiandrogenic activity, and cimetidine-induced gynecomastia and impotence in hypersecretory patients have resolved when Zantac has been substituted. However, occasional cases of gynecomastia, impotence, and loss of libido have been reported in male patients receiving Zantac, but the incidence did not differ from that in the general population.
Integumentary: Rash, including rare cases suggestive of mild erythema multiforme, and, rarely, alopecia.
Other: Rare cases of hypersensitivity reactions (e.g., bronchospasm, fever, rash, eosinophilia), anaphylaxis, angioneurotic edema, and small increases in serum creatinine.

OVERDOSAGE: Information concerning possible overdosage and its treatment appears in the full prescribing information.

DOSAGE AND ADMINISTRATION: (See complete prescribing information in Zantac® product labeling.)
Active Duodenal Ulcer: The current recommended adult oral dosage is 150 mg or 10 mL (2 teaspoonfuls equivalent to 150 mg of ranitidine) twice daily. An alternative dosage of 300 mg or 20 mL (4 teaspoonfuls equivalent to 300 mg of ranitidine) once daily at bedtime can be used for patients in whom dosing convenience is important. The advantages of one treatment regimen compared to the other in a particular patient population have yet to be demonstrated.
Maintenance Therapy: The current recommended adult oral dosage is 150 mg or 10 mL (2 teaspoonfuls equivalent to 150 mg of ranitidine) at bedtime.
Pathological Hypersecretory Conditions (such as Zollinger-Ellison syndrome): The current recommended adult oral dosage is 150 mg or 10 mL (2 teaspoonfuls equivalent to 150 mg of ranitidine) twice a day. In some patients it may be necessary to administer Zantac® 150-mg doses more frequently. Dosages should be adjusted to individual patient needs, and should continue as long as clinically indicated. Dosages up to 6 g per day have been employed in patients with severe disease.
Benign Gastric Ulcer: The current recommended adult oral dosage is 150 mg or 10 mL (2 teaspoonfuls equivalent to 150 mg of ranitidine) twice a day.
GERD: The current recommended adult oral dosage is 150 mg or 10 mL (2 teaspoonfuls equivalent to 150 mg of ranitidine) twice a day.
Erosive Esophagitis: The current recommended adult oral dosage is 150 mg or 10 mL (2 teaspoonfuls equivalent to 150 mg of ranitidine) four times a day.
Dosage Adjustment for Patients With Impaired Renal Function: On the basis of experience with a group of subjects with severely impaired renal function treated with Zantac, the recommended dosage in patients with a creatinine clearance less than 50 mL per minute is 150 mg or 10 mL (2 teaspoonfuls equivalent to 150 mg of ranitidine) every 24 hours. Should the patient's condition require, the frequency of dosing may be increased to every 12 hours or even further with caution. Hemodialysis reduces the level of circulating ranitidine. Ideally, the dosing schedule should be adjusted so that the timing of a scheduled dose coincides with the end of hemodialysis.

HOW SUPPLIED: Zantac® 150 Tablets (ranitidine HCl equivalent to 150 mg of ranitidine) are peach, film-coated, five-sided tablets embossed with "ZANTAC 150" on one side and "Glaxo" on the other. They are available in bottles of 60 (NDC 0173-0344-42) and 100 (NDC 0173-0344-09) tablets and unit dose packs of 100 (NDC 0173-0344-47) tablets.

Zantac® 300 Tablets (ranitidine HCl equivalent to 300 mg of ranitidine) are yellow, film-coated, capsule-shaped tablets embossed with "ZANTAC 300" on one side and "Glaxo" on the other. They are available in bottles of 30 (NDC 0173-0393-40) tablets and unit dose packs of 100 (NDC 0173-0393-47) tablets.

Store between 15° and 30°C (59° and 86°F) in a dry place. Protect from light. Replace cap securely after each opening.

Zantac® Syrup, a clear, peppermint-flavored liquid, contains 16.8 mg of ranitidine HCl equivalent to 15 mg of ranitidine per 1 mL in bottles of 16 fluid ounces (one pint) (NDC 0173-0383-54).

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May 1992
2130A

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Please see Brief Summary of Prescribing Information on adjacent page.

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November 1992

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Newswatch

COMPETITION IN UNCOMPENSATED CARE...

MSNJ President William E. Ryan, MD, is publicly advocating competitive solutions to the state's uncompensated care crisis. Dr. Ryan proposed that the state subsidize a health insurance package, tied to managed care and offering a basic level of benefits, for Medicaid-eligible and near-Medicaid-eligible consumers. MSNJ's proposal also would reduce regulatory programs and would establish tort reforms to prevent nonmeritorious malpractice claims. In addition, the proposal would provide transition support to hospitals as they convert to a competitive system. Under the competition model, various vendors--insurers, HMOs, and other entities--could offer packages that would meet specifications set by a quasi-regulatory board. The new board would replace several existing state boards. To pay for the insurance subsidies, New Jersey's constitution would have to be amended to allow revenue from a new income tax surcharge to be dedicated to this purpose. Meanwhile, the hospital transition funding would come from multiple sources, including health promotion taxes on tobacco and alcohol products. These long- and short-term funding sources would replace the 19 percent surcharge now added to hospital bills. The surtax was struck down by a federal judge in May, triggering the state's uncompensated care crisis.

MSNJ COMMENTS ON PHASE 2 OF STATE HEALTH PLAN...

Softening its opposition to the State Health Plan, MSNJ has provided Governor Jim Florio with comments that generally

support the development of the Plan's Phase 2. MSNJ had led much of the fight against Phase 1, which proposed a heavy regulatory approach, severe cuts in hospital beds, and the closure of many hospital pediatric units. Phase 2 is less hospital-oriented and addresses preventive and primary care, surgery, renal dialysis, cancer, diabetes, occupational and environmental health, mental health, injuries, and AIDS.

MSNJ's key Phase 2 recommendations include: establishment of a Task Force on Administrative Costs to cut down on unnecessary expenses; development of a statewide system of primary care, and a primary care telephone hotline to assist providers, educators, medical students, and others; and creation of a state campaign against violence. The recommendations also include a public-private partnership to avoid confrontation and inflammatory rhetoric in the further development of the Plan.

Public hearings on the Plan are December 1, 3, 15, and 17, 1992. For information, call Karen Monsees at MSNJ headquarters or call your county society.

AMA BACKS OFF MANDATORY FEE POSTING...

Clarifying an earlier communication, the AMA says that physicians are not required to post in office waiting rooms their fees for the ten procedures that the individual physician most frequently performs. Such fee posting is merely illustrative of ways doctors could provide appropriate cost information to the public, says the AMA.

November 1992

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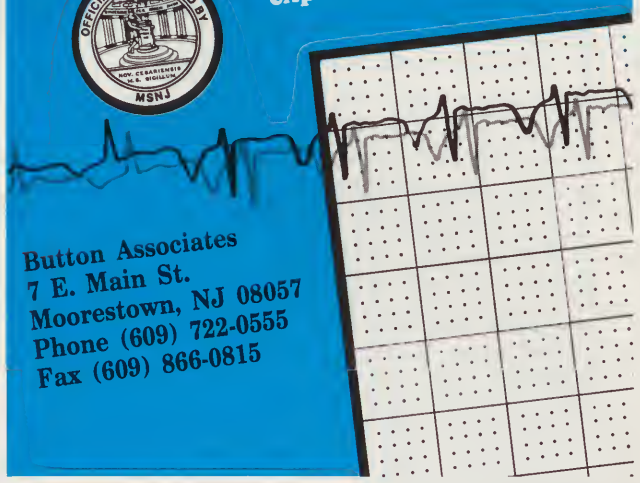
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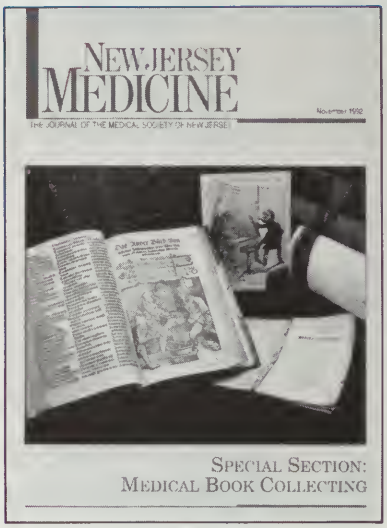
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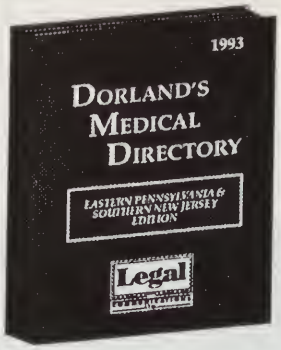
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MSNJ NEWSLETTER

GEORGE F. SMITH LIBRARY EXHIBIT

Harrison S. Martland, MD, a famed Newark physician, and his research in industrial radium poisoning, is the focus of an exhibit on radiation at the Newark campus of UMDNJ. "Radium and Radiation, 1896-1993" will be on display in the exhibition gallery of UMDNJ-George F. Smith Library of the Health Sciences through January.

Dr. Martland, former Essex County medical examiner, pathologist, and instructor at Newark City Hospital from 1908 to the early 1950s, gained medical renown for demonstrating the adverse effects of radium on the body. He made this discovery while investigating a group of West Orange women who had similar ailments and who all worked in a local factory painting the numbers on clock faces with radium. The women became known as the "radium dial painters."

The exhibit also features displays about Henri Becquerel's discovery of natural radioactivity in 1896 and the problem high levels of radon present to New Jersey homeowners today.

The exhibit will be on view in the library, 30 Twelfth Avenue. The exhibit closes at the end of January and will reopen in April 1993, remaining on display until September 1993. For more information on the exhibit, call 1/201/456-6293.

ACTIONS BY THE DEPARTMENT OF HUMAN SERVICES

The New Jersey State Department of Human Services is developing new regulations on hospice services and on prescription policies involving Medicaid, Pharmaceutical Assistance to the Aged and Disabled (PAAD), and nursing homes. Additional information may be available from the office of the legal and regulatory liaison of the departmental division that manages Medicaid programs, 1/609/588-2655.

The Department also has distributed a 14-page memorandum detailing $250 million in budget cuts mandated by the Legislature. Health-related cuts include: $5 million in funding for four state psychiatric hospitals; $417,000 in case management for homeless people; $10 million in government funds for the Garden State Health Plan, the Department's health maintenance organization (HMO) for Medicaid, as capitation rates will be frozen; copay increases from $2 to $5 per prescription for PAAD participants, who purchase an average of 23 prescriptions per year; closing many of the 17 Medicaid district offices in the state, which communicate with the public and providers; and closing a 30-bed developmental center on the grounds of Ancora Psychiatric Hospital. According to the memorandum, the Department also would lay off 627 state employees.

VACCINE BROCHURES AVAILABLE

Brochures and forms that are now federally required for the administration of polio, measles, DTP, mumps, rubella, and tetanus vaccines are available at no charge, in a limited supply, to Medical Society of New Jersey members. The materials were provided by Connaught Laboratories, Inc. Contact Addie Holden at MSNJ executive offices, 1/609/896-1766.

AIDS AGENDA ADVANCED

A report of the Governor's Advisory Council on AIDS is being finalized for submission to Governor Jim Florio and legislative leaders. The report will concentrate on the need for stronger action to address the epidemic, including school-based education and consideration of aggressive measures such as needle exchange programs for intravenous drug users and condom distribution in prisons. The Medical Society of New Jersey (MSNJ) is one of many groups represented on the Commission chaired by noted bioethics attorney Paul W. Armstrong.

In the meantime MSNJ's recently reconstituted Committee on AIDS, chaired by pediatric infectious disease specialist Lawrence D. Frenkel, MD, is seeking to develop a legislative strategy. Committee members hope to steer a path between a punitive approach and an approach reflecting excessive sensitivity to concerns about civil liberties.

ACP OUT IN FRONT OF ITS MEMBERS?

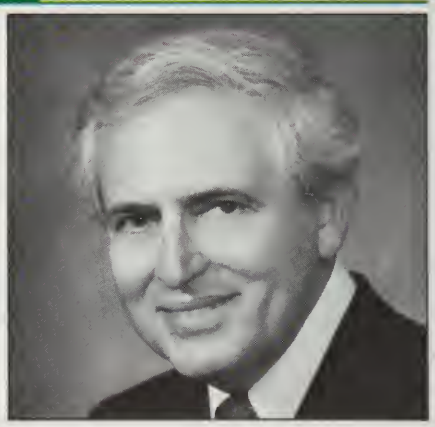
Although praised by some Democratic Party leaders and advocates of government-oriented national health reform, the American College of Physicians' (ACP) recent endorsement of global health care budgeting may cause the organization to face problems with its members. Representatives of ACP and the American Society of Internal Medicine both told the Physician Payment Review Commission that most internists have not benefited from Medicare's use of resource-based relative value scales (RBRVS), which some observers see as a precursor of global budgeting.

COST PLUS 10 PERCENT RULE

Reeling from confusion, concern, and litigation over a proposed regulation prohibiting physicians from charging patients more than 110 percent of their base costs of ancillary drugs, goods, and medical devices, the State Board of Medical Examiners is considering a compromise proposal that removes the 110 percent formula. Under consideration is the following language: "A Board licensee shall derive his or her net professional income from the rendering of professional service. The practitioner may recoup the actual cost of providing those goods and devices which are ancillary to the primary professional service as well as the costs associated with the provision thereof, but the licensee shall not charge for these items a fee intended to generate a profit."

NJ OPHTHALMOLOGIST WINS HONOR AWARD

David Soll, MD, a member of our Camden County component, and a clinical professor at Robert Wood Johnson Medical School has been chosen for the highest honor bestowed by the American Academy of Ophthalmology for public and professional service, the Senior Honor Award. The eye physician and surgeon will receive the award at the Annual Meeting of the American Academy of Ophthalmology (AAO) on November 8-12, 1992. The annual award recognizes ophthalmologists who have made significant contributions to the profession. □



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PROFESSIONAL LIABILITY

MALPRACTICE TIPS

Diagnosing breast cancer. Two recently summarized studies have generated possible explanations for failures to diagnose breast cancer in a timely manner. A 20-year study of malpractice cases, reported in *Archives of Surgery* in May, suggested that physicians may fail: (1) to appreciate that almost one in four cases of breast cancer occurs in women under the age of 55 years; (2) to recognize the remote possibility of breast cancer in pregnant women; (3) to perform a biopsy of a symptomatic breast lump before diagnosing fibrocystic disease; (4) to appreciate the limitations of mammography, especially in young women; and (5) to cytologically investigate asymptomatic nodularity.

Another investigation, performed by the Breast Cancer Advisory Group of the Harvard Risk Management Foundation, led to recommendations of: alertness to the possibility of breast cancer in young, pregnant, and lactating women; more frequent examinations; careful attention to patients' complaints and symptoms; consideration of subtle findings; and greater use of needle and open biopsies. Both studies were summarized in *Medical Liability Monitor.*

More on communication. Why do patients change physicians or initiate malpractice suits? Reasons include long waits for appointments or in waiting rooms, as well as rude or insensitive staff behavior and misunderstandings about bills. Poor communication, especially poor listening, is a major factor. In one recent study, physicians interrupted more than three-fourths of the opening statements of patients, and the interruptions occurred an average of only 18 seconds after the patient began speaking.

Another recent study revealed patients' interest in improved physician communication about treatment options, inquiring about presenting complaints, soliciting questions, and confirming the patient's understanding of what the physician has said. Other communication problems that have surfaced include the failure to return patients' telephone calls, and perceptions that office staff regard scheduling an appointment as a favor done for the patient.

Reporting these findings, the monthly newsletter *Loss Minimizer* suggests that physicians conduct written surveys, with questions such as: "In which areas of our practice do you think we need improvement?" The newsletter also suggests the use of focus groups of patients, and frequent inquiries of staff about complaints.

Other suggestions offered by the newsletter include the maintenance of timely and meaningful medical records, especially in group practices, and systematic patient education.

Wrong-side surgery. The Pennsylvania Medical Society's Liability Insurance Company has noted several suggestions made by physicians for reducing the incidence of surgical procedures performed on the wrong side of the patient. One method is to ask the alert patient to identify the correct side in the operating room. A complementary technique is to mark the correct operative site with an "X" that is not to be obliterated by Betadine®. Noting the side of the condition in all notations on the medical record also is recommended. And, an ophthalmologist reported applying stickers above the eyebrow.

HEALTH CARE FINANCING

Rationing and malpractice. In an article published in *University of Pennsylvania Law Review,* American Medical Association associate general counsel Edward B. Hirshfeld has discussed the relationship of malpractice law to the proposed "rationing" of health care. Mr. Hirshfeld admonishes that rationing may be necessary to control health care costs in the presence of such cost-escalating factors as an aging population and rapidly advancing medical technologies—even though, as he asserts in a footnote, "the dominant theme" in U.S. health policy for the past half-century has been "to eliminate rationing."

Explicit rationing is politically unacceptable, Mr. Hirshfeld acknowledges. And, implicit rationing, conducted through HMO-type market pressures or the use of practice parameters, requires physicians to exercise judgments colored by economic considerations that physicians traditionally have ignored. The challenge, then, is to define, for physicians and patients, a "boundary" between rationing and the acceptable withholding of unnecessary medical care.

Mr. Hirshfeld incisively observes a lack of medical terminology for expressing either the probability or the extent that a medical service will benefit the patient. The physician's orientation is to do what is best for the patient, without regard for ex-

traneous considerations such as global budgets or benefit-cost ratios. Indeed, tort law, through the standard-of-care principle applied in malpractice cases, contemplates single-minded dedication to the patient.

If the tort law were changed, however, physicians could be expected to make resource allocation decisions that would benefit some patients to the detriment of others. Mr. Hirshfeld opposes this approach, because of the negative effect it would have on patients' trust of physicians. He envisions a similarly negative effect if physicians become the enforcers of practice parameters that reflect economic considerations.

Instead, he proposes the use of democratic methods for establishing resource allocation principles that physicians then would merely apply. Application of these principles would not violate currently existing standard-of-care requirements and, in Mr. Hirshfeld's view, would not cast the physician in the role of rationer. He concludes, "The patient's interest should continue to ... serve as the foundation principle upon which guidelines to distinguish between necessary and unneeded care are built."

CLIA inspections. In a letter to James S. Todd, MD, executive vice-president of the American Medical Association, Health and Human Services Secretary Louis W. Sullivan, MD, announced that physicians generally would receive advance notice of federal inspections of office-based laboratories. The inspections are mandated under new regulations implementing the Clinical Laboratory Improvement Amendments of 1988, known as CLIA.

Dr. Sullivan's guidelines provide for three days' notice of routine inspections of laboratories where physicians and other personnel ordinarily are involved in patient care and, therefore, could not easily accommodate the inspections. Unannounced inspections still would be performed in response to individual complaints or other suspicion-raisers.

Waiving copayments. To break a chain of "delicious circularity," a federal appeals court has supported a health insurance provision that compels physicians to bill patients for copayments not reimbursed by the insurer. The U.S. Court of Appeals for the Seventh Circuit, in Chicago, interpreted a contract between a patient and a practitioner in the light of a private insurance policy covered by the Employee Retirement Income Security Act (ERISA).

The policy obligated the patient to pay approximately 20 percent of the total bill, and the policy further freed the insurer from having to reimburse charges that the insured was "not legally required to pay." The contract, meanwhile, excused the patient from having to make the 20 percent copayment. The contract, said the court, allowed the practitioner, who happened to be a chiropractor, "to say that his reasonable and customary fee was some $2,150 even though he never planned to collect more than $1,727 from anyone."

The circularity enters the picture as follows: The contract relieves the patient of having to pay the 20 percent. Thus, the insurer is relieved of having to pay the 80 percent. In turn, the contract requires the patient to pay the full 100 percent. Consequently, the policy requires the insurer to pay 80 percent. Then, the contract again kicks in, freeing the patient of the 20 percent obligation. "And so it goes."

To break the circle, the court granted primacy to the insurance policy, saying that a practitioner must collect, or at least bill, patients for the required copayments in order to collect reimbursement from the insurer. The ruling may be limited, however, to circumstances in which there is an actual agreement between the practitioner and patient. The case was written up in the October 1992 issue of *Hospital Law Newsletter.*

G-men on alert. In a strategic plan developed by the White Collar Crimes Section of the Criminal Investigative Division, the Federal Bureau of Investigation (FBI) has proposed a campaign to clamp down on health care fraud. The campaign would be run by a new health care fraud unit and dedicated squads in FBI field offices.

False claims submitted for services that were not rendered at all, or for more expensive services than those that were rendered, head the list of suspicious activities depicted in the plan. The Bureau justifies the plan by stating that at least 5 percent of the nation's huge health care bill is fraudulent. There is no intent to focus on physicians alone.

MALPRACTICE POLICY DEVELOPMENTS

Malpractice research. One year after first devoting a monthly issue to malpractice, a publication of The Robert Wood Johnson Foundation in Princeton has reexamined the malpractice terrain. The publication, *ABridge,* concluded: "Reform movement has increased because of a growing recognition that conventional tort reform alone won't be enough to resolve the medical malpractice problem and that a more comprehensive solution is needed. Research ... has shown that the 'big three' reforms—caps on damages, collateral source rulings, and shorter statutes of limitations—aren't the panaceas they were heralded to be."

One study that was part of the Foundation's Medical Malpractice Program used data obtained from "a physician-owned medical malpractice insurance carrier that provides liability coverage to about 70 percent of New Jersey's

doctors." Analyzed were claims involving obstetrics-gynecology, general surgery, anesthesiology, and radiology between 1977 and 1989. In all four specialties patient management errors were most frequently cited as causes of negligence.

Fewer than 15 percent of the claims examined in the New Jersey study involved the failure to order diagnostic tests or to apply monitoring techniques. Defensive medicine, therefore, appears to provide scant protection against malpractice suits.

New Jersey data also led to the conclusion that malpractice history is only a "moderately accurate" predictor of future claims. Consequently, the researchers recommended caution in the use of the National Practitioner Data Bank as a source of information for identifying problem physicians.

Foundation-supported research also demonstrated that Medicaid recipients are no more likely than privately insured patients to sue their doctors, so that fear of malpractice claims is no reason for physicians to decline to participate in Medicaid. Another conclusion is that caps on damages are an "inappropriate" reform, because excessive compensation is rare.

In an obstetrics-based study other researchers examined the potential of using accelerated-compensation events (ACEs) to streamline the malpractice system. This method involves channeling, outside of the court system, injuries that meet predetermined criteria that involve such characteristics as ease of identification, high probability of prevention through good care, and low probability of prevention through inappropriate procedures. The study supported the idea of a large field test of the ACE approach.

Hospital-based research demonstrated the wisdom of risk management programs, especially programs tied to physician education about risk management, formal communication with patients and families when adverse events occur, and an organizational framework for using information obtained through occurrence screening or incident reports.

Malpractice conference. On November 20, the Tenth Annual Conference on Medical Malpractice Issues will convene in New York City. Scheduled speakers include: Walter Wadlington, Esquire, director of The Robert Wood Johnson Foundation's Medical Malpractice Program; Troyen Brennan, MD, JD, MPH, of Harvard Medical School; and New York State Health Commissioner Mark Chassin, MD. Topics include practice guidelines, managed care, products liability, and congressional interest in malpractice reform. For information, call 1/212/891-0709.

MIIX rankings. In 1991 figures recently reproduced in *Medical Liability Monitor,* New Jersey's Medical Inter-Insurance Exchange ranked sixth in the number of physicians covered, fourth in amount of assets, sixth in the size of its surplus, and fifth in the gross value of premiums. Forty-two physician-owned companies were surveyed.

MALPRACTICE VERDICTS

Fatty tissue around eye. A recent New Jersey malpractice case involved a woman in her 60s who presented to an ophthalmologist with cholesterol deposits and excess lower eyelid tissue. The ophthalmologist removed the tissue for cosmetic and vision reasons. The patient later sued, contending that too much tissue was removed, causing severe downward pulling of the eyelid that required two plastic surgery procedures.

In defense the physician asserted that the care was properly performed and the patient suffered a known complication, the formation of scar tissue. The verdict was for the defense.

Kidney needle biopsies. Another New Jersey trial involved a woman in her 50s who received a needle biopsy of two kidney lesions. The plaintiff contended that the urologist had identified only one of the lesions as suspicious, and that the radiologist had proceeded to test both lesions despite her protest. The second biopsy, said the plaintiff, could not be completed due to complications that led her to suffer breathing problems for one day. The second procedure, she claimed, amounted to a battery, and she also brought malpractice claims against both physicians.

In defense, the radiologist maintained that the patient, after some initial protest, did consent to the second procedure. The urologist said that the second lesion was the suspicious one. The jury brought in a verdict for both doctors. ☐ James E. George, MD, JD; Neil E. Weisfeld, JD, MSHyg



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BOOK REVIEWS

ADVANCES IN SURGERY

John Cameron, MD. Philadelphia, PA, Mosby-Year Book, 1992. We are living in an era of increasing numbers of journals and publications and an almost hypersonic increase in new knowledge that directly affects clinical practice. It is difficult for the conscientious clinician to keep current with the literature.

Advances in Surgery, Volume 25 provides the practicing surgeon with a series of up-to-date reviews of current topics in surgery. The present edition is edited by Dr. John Cameron with a distinguished staff of assistant editors. The cover announces that this is the 25th edition, attesting to the staying power and popularity of this series.

This year's volume contains reviews on 13 topics. Six of these reviews are highly practical technical overviews of newer aspects in surgery ranging from laparoscopic cholecystectomy to the current status of the Whipple operation. Two reviews deal with basic aspects of surgery, such as possible applications of growth factors. One review is an excellent discussion of the differential diagnosis of intestinal bleeding. All the reviews are well written. The illustrations are clear and well presented. Crist and Cameron's discussion of the Whipple operation is particularly well done. I would highly recommend this volume to any practicing general surgeon or general surgical resident to keep abreast of the current literature. □ Benjamin F. Rush, MD

ATLAS OF REGIONAL ANESTHESIA

David Brown, MD. Philadelphia, PA, W.B. Saunders, 1992. The introductory chapter reviews various agents and reasons for utilizing each, as well as the types of needles, syringes, and catheters utilized. The chapter also includes an explanation of the use of nerve stimulators to ascertain successful block.

The author uses a technique called the three "P's," i.e. perspective of the block anatomically, functionally, and physiologically; placement of the block or technique; and pearls—nuggets of wisdom learned from the author's actual practice.

The author advocates the use of balanced anesthesia, i.e. appropriate sedation prior to and following the block. The illustrations make good use of color, especially in the sections showing neural innervations. The anatomy is described in simple and clear terms reminiscent of Frank Netter, and the block techniques and agents recommended are fully explained along with the caveats, advantages, and "pearls."

The text covers 40 blocks that should suffice for even the most meticulous generalist. The book, subtitled "An Atlas," proves the point that a picture is worth a thousand words. This publication should guarantee anyone attempting regional anesthesia a much easier and more informed practice. It is highly recommended. □ Stanley Bresticker, MD

AUTOIMMUNITY

W. Ollier and D.P.M. Symmons. Oxford, England, BIOS Scientific Publishers, 1992. Autoimmunity is a concept every clinician should be familiar with because it can affect any organ system of the body. With the field of immunology constantly grow-

ing, this book successfully puts into perspective the various aspects that pertain to the loss of the body's normal ability to distinguish self from nonself.

The authors begin by describing the normal role of the immune system and introduce the concept of autoimmunity. They present various theories concerning the development of autoimmunity and how animal models have contributed to the understanding of this concept. In a very clear and concise manner, Drs. Ollier and Symmons tackle the role of genetics in the development of autoimmunity describing the role of HLA and its disease associations. We particularly enjoyed reading chapters 3 and 4, dealing with the definition and characterization of autoantigens and the consequences of autoimmunity at the cellular and humoral level. The authors discuss the possible environmental triggers for autoimmunity including retroviruses, heat shock proteins, and superantigens. We were impressed at how clearly, with the help of diagrams, Drs. Ollier and Symmons describe the various methods used for detecting autoantibodies by immunofluorescence, ELISA techniques, radioisotopic methods, and various types of immunodiffusion. They proceed by elaborating on the three main immunopathologic processes for autoimmunity: direct involvement of autoantibody, deposition of immune complexes, and lymphocytic infiltration of specific organs.

The latter part of the book correlates the basic concepts of autoimmunity with specific multisystem and organ specific autoimmune diseases briefly mentioning various treatment options and touching on experimental immunomodulation where exciting research is likely to yield major therapeutic breakthroughs. There are many unanswered questions regarding the process of autoimmunity and we strongly agree with the authors that a close collaboration between the basic scientist and the clinician is required for progress to be made in this field. This book is a first step.

We recommend this easily digestible book to medical and postgraduate students as well as to any clinician interested in autoimmune diseases and the basic immunological processes that may explain these fascinating diseases. ☐ Ligaya Cetano, MD, and Leonard Bielory, MD

PEDIATRIC AND ADOLESCENT GYNECOLOGY

Sue Ellen Koehler Carpenter and John A. Rock. New York, NY, Raven Press, 1992. The editors commissioned 40 distinguished academicians and clinicians to contribute 29 chapters covering every aspect of pediatric and adolescent gynecology that might be encountered in a lifetime of practice. Since we have been living during these past 20 years in an era in which children are trying to act like adults and adults are acting like children, the material presented in this excellent textbook actually covers current knowledge of all gynecologic problems up to the menopausal years and beyond.

For the sake of completeness, most textbooks cannot avoid or ignore the rare and unusual, such as congenital anomalies, and every obstetrician-gynecologist will be called upon to offer advice, reassurance, and followup care to those with rare conditions and/or to their families despite referral to specialists. This book provides an excellent source of up-to-date information for all conditions, including references, and intellectual stimulation that is refreshing and valuable.

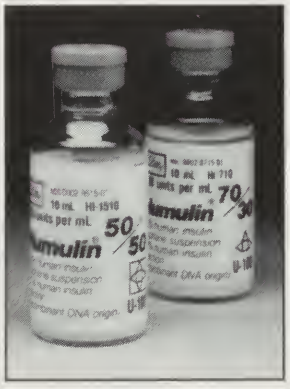
This book is recommended to obstetrician-gynecologists and to specialists who all too readily appear ignorant or disinterested in anything beyond a narrow purview of expertise, tossing patients back and forth among themselves while the generalist tries to referee and placate. ☐ Jerome Abrams, MD, MPH



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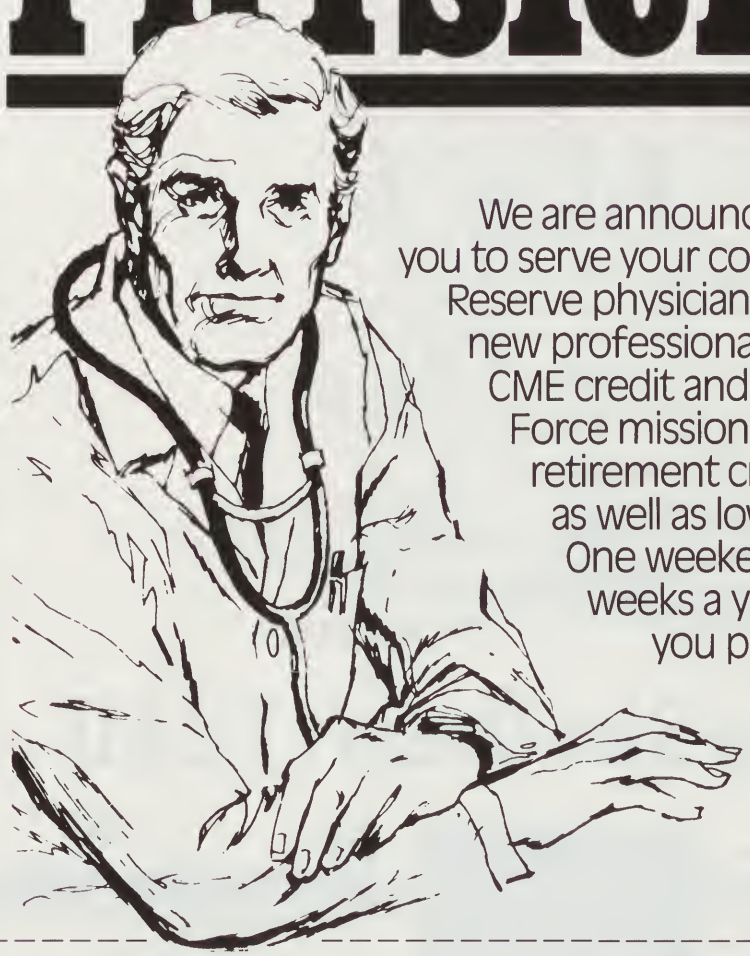
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EDITOR'S DESK

PANACEAS

One of the greats of American medicine died on September 11, 1992. George Washington Crile, Jr, MD, was an outstanding physician and surgeon and, perhaps most importantly, a leading critic of the status quo. When radical neck dissections were standard treatment for nodal involvement in carcinoma of the thyroid, the so-called "lateral oberrant thyroid," his results with nonradical removal of involved nodes in combination with primary thyroid resection showed equivalent results. When Scottish physicians demonstrated, to his satisfaction, similar results by treating breast cancer with lesser surgery and radiation therapy, Dr. Crile abandoned the practice of the time, the radical mastectomy, and published results indicating the effectiveness of the alternative method.

He was the son of an equally distinguished surgeon, one of the founders of the Cleveland Clinic, where both spent their productive years. Perhaps as a result of this environment, Dr. Crile became a true believer in the physician as a salaried employee. We wrote some years ago about the well-known debate he had with Dr. Francis Moore of Boston as published by *Medical Economics.* Dr. Moore argued on the side of fee-for-service. Dr. Crile argued on the side of salaried positions; the result was a Mexican standoff. Today Dr. Crile would have numerous allies. Many economists, some self-taught, including editorial representatives from *The New England Journal of Medicine,* recommend salaries for physicians as part of a cure-all for what ails the delivery of health care in the United States.

Imagine the changes needed to shift from the present systems of



Howard D. Slobodien, MD

physician payment to a pure salaried program. Can we really salary everybody? Do capitation fees substitute equitably for salaries? If so who, besides primary care physicians, should be included? How do limited-license practitioners fit into the overall scheme? Will we have two groups, one hospital- or clinic-based and the other in private offices? Or will all of us be employees of large clinics, like Cleveland, Mayo, and Lahey?

There are many other proposals for changing the delivery of health care and they have proliferated during this election year. Some proposals will be considered to be serious, others frivolous and pie-in-the-sky. Many proposals have meritorious elements, few are feasible politically. We have even seen the recent tentative plan offered by two New Jersey state senators to solve all paperwork by the use of "smart cards." Another scheme has the potential to divide the medical profession even further—the recent offering by the American College of Physicians (ACP), which contradicts some of the policies adopted by the House of Delegates of the American Medical Association (AMA) this past June. It is decried by some of the ACP state chapters, including the one in our state. The ACP may have 77,000 members, but it apparently does not speak for them. There are few national medical organizations, other than the AMA, that are democratic in activity from the grassroots to the top.

The action by the ACP probably should have surprised none. The AMA launched its Health Access America program in March 1990. The ACP, also in Chicago, rejected the plan the following month, although it said it had no plan of its own. But five years of cogitation went into their plan, which was revealed in the September 15, 1992, issue of the *Annals of Internal Medicine.* Where was the ACP when the AMA was developing Health Access America?

Organizations in New Jersey have been considering both national and local problems. The leadership of MSNJ has been working intensively and, in a welcome change, has been able to have major input into various deliberations, especially in the Coalition for Health Care Reform, as reported previously in the Newswatch section of *NEW JERSEY MEDICINE.* It also was noted that MSNJ is a member of the Coalition for a Healthy New Jersey (CHNJ), a unique and most interesting group.

On September 21, 1992, Dr. John Slade, a member of the Editorial Board of this journal, presented the CHNJ proposal for a "health promotion tax" to raise

an estimated $493 million by increasing the levies on butts and booze. It was recommended that the revenue be used to substitute for the Uncompensated Care Fund and for various programs to help prevent drunken driving and its aftermath.

The counterattack to the "sin tax," as some have dubbed it, was both expected and educational. Did you know, for example, that New Jersey has 25,000 members of Beer Drinkers of America? Or that taxation causes a decrease in liquor consumption? (Previous studies showed that increased costs or decreased income had no effect on the amount of alcohol consumed; cheaper brands were used.) Did you realize that bootlegging is a serious problem in New Jersey? Don't you feel that smokers should have plenty of room to smoke in public buildings erected with the help of tax money, part of which derives from cigarette taxes? Do you believe that those who oppose the "sin tax" would concede that smokers and drinkers are responsible for higher community health expenditures? Do you also believe in the tooth fairy?

As noted, many proposals for the restructuring of the delivery of health care have been laid on the table. By the time you read this editorial, the nation will have elected a new president and the direction of change may be better defined. We also have seen the introduction in the Congress of the United States of the "New Jersey exemption law," sponsored by Senators Bradley and Durenberger. This is a measure designed to allow us to once again shift costs for hospital care—billing as usual. Unfortunately, this bill acts as an evasive, counterproductive roadblock to the true reform we need and has received well-deserved adverse criticism, with which we agree.

Let us all endeavor to keep informed, monitor changes, and participate as actively as possible in the efforts to effect salutory health care reform. We can make a difference and the benefits will accrue to all of us and especially to our patients. ☐ Howard D. Slobodien, MD

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Hippocrates
Aphorisms, c. 400 B.C.

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PRESIDENT 'S PAGE

PAYING FOR HEALTH CARE

Health care is a right and not a privilege. Paying for this right is an entirely different issue. We are enmeshed in the debate over who pays for "uncompensated care" and other issues. Replacing the funding mechanism for uncompensated care has been an eye-opening experience. The fund underwrote $800 million worth of care for the poor and for "bad debt" and other shortfalls.

The Medical Society of New Jersey (MSNJ) is a member of the Coalition for Health Care Reform. The Coalition meets weekly to grapple with the issues and to suggest solutions to the problems. The biggest issue is funding.

Paying for this societal concern with a broad-based tax seems most logical, but there is little support for a personal income tax or a payroll tax as one might expect during an election year. A series of health promotion taxes ("sin taxes") has been introduced by the Coalition for a Healthy New Jersey (CHNJ). CHNJ spokesman John Slade, MD, a physician at St. Peter's Medical Center and Robert Wood Johnson Medical School, has advanced the proposal that across-the-board increases occur in cigarettes and other tobacco products, beer, wine, and liquor. It is suggested that the cigarette tax be increased from $.40 to $1.40 per pack and that liquor be increased from a current tax of $4.40 per gallon to $6.38 per gallon. It is estimated that these taxes would raise $493 million—87 percent would go toward the cost of treating the indigent. The justification for these



William E. Ryan, MD

taxes is that consumption of these substances significantly adds to the dollars spent each year on health care costs so that these consumers are defraying their just share of the burden. Obviously, there is opposition from the tobacco and liquor industry.

MSNJ's chief concern has been to avoid a provider tax. A "sick tax" or a tax on health services has been suggested. This has been opposed by unions and third-party carriers who see it as expense to them, an increased premium burden, and "ERISA all over again."

A provider tax is singularly unfair. No other segment of our economy is asked to pay a similar tax for provision of services that is a societal concern. Attorneys are not asked to pay court costs when they defend the indigent. Social workers and social service agencies are not asked for financial remuneration when they assist victims of abuse or poverty. Supermarkets are not asked to pay for food stamps. Society's fundamental obligations are met through broad-based taxes. Physicians and hospitals rendering necessary and vital services should be treated no differently.

Additionally, the provider tax rubs salt into the wound. Dr. Molly Coye, former commissioner of health, indicated that in 1989, physicians in New Jersey gave $500 million in free medical care. We always have considered true charity care to be our obligation and have more than done our duty. We do not feel we should share a tax responsibility.

In Minnesota, a 2 percent tax has been levied on physicians' gross income, beginning on January 1, 1994. Other states are considering a provider tax. It can happen and it will happen if we are not vigilant and aggressive in our opposition.

During the next few weeks, please write to your assemblymen and senators since they will have proposals before them concerning the funding mechanism. Volunteer to meet with them personally. Please make yourself available for any activities that may be necessary in Trenton.

We were successful in beating off mandatory Medicare assignment because of the tenacity, diligence, and political activities of our membership. The time for similar action is at hand. □ William E. Ryan, MD

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The Legacy of New Jersey Physician Book Collectors

Barbara S. Irwin, MLS

This article offers a brief history of the development of New Jersey's major history of medicine collection, and an overview of selected resources currently available to researchers. Old and rare medical books now are available to a new generation of physicians and scholars.

The first successful attempt to create a medical library in New Jersey took place on November 18, 1905, when a group of physicians met at the Newark Public Library.[1] Dr. Charles J. Kipp (1838-1911), founder of the city's first eye and ear clinic at Saint Michael's Hospital in 1870, was elected president (Figure 1). The group was encouraged by the director of the Newark Public Library, John Cotton Dana (1856-1929), who had come to Newark from Colorado where he successfully organized a medical collection in the Denver Public Library.[2] Mr. Dana not only offered moral support, but he provided an alcove for the collection in the new Newark Public Library at 5 Washington Street.

The Medical Library Association of Newark (MLAN) was incorporated on April 19, 1906. The public library provided financial assistance for staff and $100 for the purchase of medical periodicals. In the first year, the library grew to 43 periodicals and over 750 volumes. The New York Academy of Medicine contributed 53 volumes and another 445 volumes from the estate of Dr. P.V.P. Hewett, a recently deceased MLAN member. MLAN had 130 "subscribers" and 21 new members who paid annual dues of $3. The only problem was that no one was using the collection.

To stimulate use, MLAN issued a catalogue during its second year and mailed it to members.[3] There were 26 subject categories in the 16-page pamphlet. Over the next few years, the collection increased as did efforts to encourage researchers. In 1913, an article in a local popular magazine advised the general public that they were welcome to consult the books "primarily for the use of the physicians of the city."[4] In the same issue, Mr. Dana praised the work of Dr. Frank W. Pinneo (1866-1937) who enlisted the "cooperation of many of the foremost medical men in the vicinity" in founding and building the collection.[5]

In the meantime, the Academy of Medicine of Northern New Jersey was organized at a meeting in the public library on February 25, 1911. The Academy established dual goals: "the investigation and promotion of the science and art of medicine, and the maintenance of a public medical library." A distinguished physician, Dr. Edward J. Ill (1854-1942) was elected president; Dr. Ill was a former president of the Essex County Medical Society and of the Medical Society of New Jersey (Figure 2).[6]

A great deal of Academy attention over the next nine years focused on finding a headquarters and establishing a library despite the existence of the collection at the public library. As the prospect of permanent headquarters grew closer, Dr. William Disbrow (1861-1922), executive librarian since 1912, presented his extensive collections of books, pictures, and medical artifacts to the Academy in 1919. The donation was accepted with enthusiasm by the Academy Council that promptly passed a resolution establishing a museum in his name.[7] Other gifts continued to flow into the Academy. When a brownstone at 91 Lincoln Park in Newark was purchased in 1920, a sizeable collection had accumulated and the goal of an Academy library was possible at last. To support the library, the Council created a Library Fund in 1922 and solicited contributions.[8]

A major donation to the library came in 1924 from Dr. Edward J. Ill: his collection of books and prints on "ancient medicine."[9] Other major gifts were received from Dr. James F. Condon, Dr. Edgar Cardwell, Princeton University Library, and the defunct Essex County College of Medicine and Surgery. Dr. Earl LeRoy Wood (1894-1982)

established the Barkhorn Memorial Fund for books on otolaryngology.

As the Academy gradually assumed a more important role for physicians throughout the state, use of the library increased, and it became the major resource for medical literature. In order to reflect this statewide influence, the Academy of Medicine of Northern New Jersey changed its name in 1953 to the Academy of Medicine of New Jersey (AMNJ).

Progress, nevertheless, brought a new set of problems, chiefly centered on the fact that AMNJ again had outgrown its headquarters. AMNJ moved to Bloomfield in 1956 where it remained until 1973 when administrative offices were moved to Union for six years and then to Lawrenceville. A different future, however, was in store for the Academy library that was created and maintained by seven librarians: Mildred V. Naylor, Harold M. Goettel, S.M. Hamill, Jerome Rauch, James Green, Jacqueline Picciano, and Rosary Gilheany.

In 1961, the future University of Medicine and Dentistry (UMDNJ)-Smith Library was founded in the Jersey City Medical Center as a component of the Seton Hall College of Medicine (SHCM). Following the state's purchase of the college in 1965 and the subsequent move to a Newark campus in 1971, AMNJ merged its collection with the future university, the College of Medicine and Dentistry of New Jersey (CMDNJ). Dr. Morris H. Saffron, chairman of the Academy's Library Committee, convinced committee members to turn the collection over to CMDNJ rather than sell it. In order not to "play favorites," he also arranged for the Academy's museum collection to be given to the Rutgers Medical School, now UMDNJ-Robert Wood Johnson Medical School; the archives of the Academy were donated to the New Jersey Historical Society.[10]



Figure 1. Dr. Charles J. Kipp.



Figure 2. Dr. Edward J. Ill.

The reasons behind the Academy's decision to relinquish the library its members had worked so many years to build have been described as follows: "In the period before World War II, there were close to 50,000 volumes on the [Academy's] shelves. . . . But as time rolled on in the post-war period it became increasingly apparent that with the demand for more complete facilities and more rapid communication the Academy no longer was in a financial position to provide these services efficiently or to sustain the rising cost of books and periodicals. After many years of anguish and during which successive administration struggled with the deteriorating situation, the Trustees finally decided to merge their holdings."[11]

Thus, AMNJ's journal and book collections were absorbed into the college library soon to occupy a spacious new building, the George F. Smith Library of the Health Sciences. AMNJ's rare and 19th century books provided the foundation for Special Collections. In 1978, the Academy formally named this resource the Morris H. Saffron Collection of Books on Historical Medicine (Figures 3 and 4).

Under the leadership of the college's library director, Philip Rosenstein (now University Librarian Emeritus), Special Collections was given a home in a handsomely furnished room, lined with custom-made mahogany shelving, located on a balcony overlooking the main reference collection. Gertrude Annan, former librarian of the New York Academy of Medicine, was hired as a consultant for the organizing and cataloguing of the collection. To publicize the availability of the collection to the scholarly community at large, a catalogue, *The Morris H. Saffron Collection*, was issued in 1980 of 528 books dating from 1513 with a special section for medical Americana. A grant from the UMDNJ-Foundation provided funds for organizing the collection, archival storage materials, and publication of the catalogue.

Over the intervening years, the University Library has expanded all its collections to better serve faculty, students, physicians, and the medical community of the state. A statewide network of libraries, the UMDNJ-University Libraries System was created in 1983. The libraries are linked via computers to make it possible for researchers—in a UMDNJ library or from their homes or offices—to search a vast union catalogue and locate journal articles. At the same time as the University Libraries' technological structure was being developed, attention also was given to the expansion of historical collections.



Figure 3. The Academy's library was donated to UMDNJ in 1978 and named "The Morris H. Saffron Collection of Books on Historical Medicine" to honor its library chairman. Dr. Saffron (right) is shown discussing one of the rare books with Philip Rosenstein, then college library director. © UMDNJ–Smith Library, Special Collections, Newark.

HISTORY OF MEDICINE COLLECTION

The Saffron catalogue provides access to rare books inherited from the Academy such as Hans von Gersdorff's *Feldbuch der Wundartzney* (1540 edition); Bartholomew Eustachius' *Anatomy Tables* (1728 edition); and Bernard Albinus' *De Ossibus Corporis* (1746 edition). There also are books by other great physicians such as Harvey, Paré, Morgagni, and Paracelsus. Many physicians also donated materials: Dr. Arthur Bernstein donated the Aaron Parsonnet Cardiology Collection, 150 volumes in the early history of cardiology. A facsimile collection was started with another donation; at present it consists of 100 titles, mainly from the "Classics in Medicine" series.

In 1990, Dr. Saffron, UMDNJ-Professor Emeritus of the History of Medicine, donated $50,000 to the UMDNJ Foundation to create two endowments: $25,000 for a medical history program at the New Jersey Medical School, and $25,000 for a book endowment for the purchase of extraordinary works or rare books. Contributions and proceeds from the sale of nonmedical materials and duplicates are being added to the book endowment.

Over the past five years, an annual donation from AMNJ has made it possible to purchase such items as 19th and early 20th century medical directories for the state, medical classics, reference books, and New Jersey materials. Academy funds have enabled the library to acquire almost 100 titles related to New Jersey medical history, 120 old and rare medical books, and three manuscript collections. The latter includes the papers of Lewis Johnson, MD (1704-1773), a Perth Amboy physician.

Special Collections has expanded beyond the concept as originally conceived in response to increasing requests for information from researchers. New Jersey Medical History Manuscript Collection contains books, pamphlets, trade catalogues, and ephemera, many of which originated in the Academy's library. Hospital histories, histories of county medical societies, biographies, and works by New Jersey physicians also are in this collection. Vertical files are maintained of newspaper clippings about New Jersey medical topics, health-related subjects, and prominent individuals. Also, there is information on women physicians including materials gathered for an original staff project, "Pioneer Women Physicians of New Jersey."

New Jersey Medical History Manuscript Collection contains primary source material. This collection began with donations from Dr. Samuel Berg (1898-1990). Dr. Berg contributed Dr. Harrison S. Martland's (1883-1954) personal scrapbooks documenting his research and correspondence related to radium poisoning, occupational medicine, and the "punch-drunk" syndrome. Dr. Berg also donated a collection of historical photographs of Newark City Hospital/Martland Medical Center (1886-1957). Dr. Sylvia Becker donated the papers of her mother, Dr. Rita Finkler (1888-1968), the state's first endocrinologist. Organization records include the Monmouth County Medical Society (1901-1949), Hudson County Medical Club (1921-1989), and the New Jersey Association for Osteopathic Physicians and Surgeons (1903-1985).

To serve researchers' requests for illustrations and photographs, three new sources were created: *New Jersey Illustration Index*, of portraits and medical-related subjects in published works; *New Jersey Photograph Archive* of original works; and *History of Medicine Print Collection.*

In 1986, a History of Osteopathy Collection was established at the Library of the UMDNJ-School of Osteopathic Medicine (SOM), Stratford, by Robert Thompson, EdD, SOM faculty member.

The University Archives is a

part of Special Collections. The Archives includes the official records of permanent value of senior officers of UMDNJ and university publications. Transcripts of interviews with UMDNJ administrators, faculty, and staff are collected in an ongoing oral history project.

In order to ensure that the collections are protected for years to come, over the past six years the Smith Library has been awarded three preservation grants. The first provided an indepth conservation evaluation of the library's environmental conditions conducted by the Northeast Document Conservation Center (NEDCC) of Massachusetts; this grant was partially funded by the National Endowment for the Humanities. A second grant was awarded by the New Jersey State Library for the preservation of the Berg Collection of photographs of Newark City Hospital/Martland Medical Center by NEDCC. The third grant, also awarded by the New Jersey State Library, was for the removal of Dr. Martland's original papers from deteriorating scrapbooks in which they were glued to archival storage containers. Concomitantly, the library funds the services of a paper conservator consultant who spends one or two days a month making repairs on books and documents.

University Librarian Victor A. Basile stated: "The significance of the Academy's gift increases in importance each year as fewer early medical books are available. Through the Saffron Collection the library is able to expose students to original works written by the great physicians about whom they read in the course of their studies. The students are able to appreciate more fully the accumulation of knowledge and the proud traditions they have chosen to carry forward. I encourage physicians to continue supporting the historical resources by donating antiquarian medical books, personal and organizational papers, and contributions to the Saffron book endowment."



Figure 4. Academy members Leo Siegel, MD, and Sherman Garrison, MD (third and fourth from left), in 1978 presented the Academy's rare book collection to UMDNJ. Accepting the donation, Stanley S. Bergen, Jr, MD (second from left), and Philip Rosenstein, Director of the G.F. Smith Library of the Health Sciences. © UMDNJ–Smith Library, Special Collections, Newark.

SUMMARY

For 70 years New Jersey physicians generously gave books from their personal libraries to create a medical library in the state. Today, the old and rare medical books they collected are available to new generations of physicians and scholars in the history of medicine collection at UMDNJ-Smith Library. ■

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Ms. Irwin is head, Special Collections and Archives, University Libraries, UMDNJ. This paper was submitted in May 1992 and accepted in June 1992. Address reprint requests to Ms. Irwin, UMDNJ–George F. Smith Library, 30 Twelfth Avenue, Newark, NJ 07103-2754.

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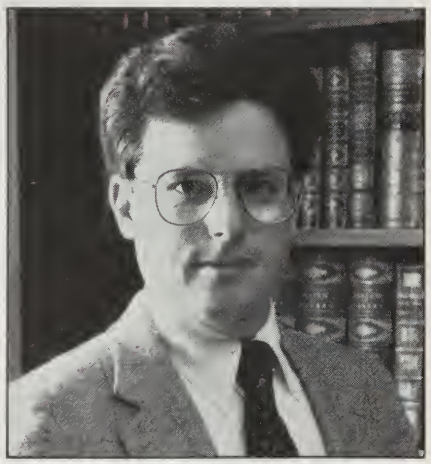
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Medical Book Collecting: A Retrospect and a Forecast

W. Bruce Fye, MD, MA

Medical book collecting and historical research are complementary pursuits. The author summarizes the contributions of bibliophiles who used their collections as a source of inspiration for historical studies and addresses the challenges confronting medical book collectors.



W. Bruce Fye, MD, MA

For many, medical book collecting and historical research are complementary pursuits.[1-4] After discussing several medical bibliophiles who have contributed to scholarship, I will consider some challenges and opportunities facing the present-day collector.

For most bibliophiles, acquisition, possession, and reading are sufficient incentives for collecting. They feel no special obligation to use their library for scholarly purposes. Just as collectors may have little interest in history, many contemporary medical historians do not collect books. Most historians have come to rely on institutional libraries; few have the desire or the resources to build a significant personal collection. I believe, however, that a closer link between book collecting and historical scholarship should be encouraged.

Books can stimulate an interest in the history of medicine as the experience of Brooklyn surgeon Lewis Pilcher shows. Writing in 1925, he confessed, "In my quest [for books], antiquarian catalogues have been my daily food; [and] I have ransacked the shelves of booksellers in many of the cities of Europe . . . Each book, as it has come into my hands has awakened renewed study and research as to the character and career of its author, and the place in the development of medicine which he and his book should have."[5] Serious collectors can identify with Pilcher's passionate search for books and his need to know something about the work's author, the context in which it appeared, and its impact on medical thought and practice.

Some might view the bibliophile as an anachronism in this computer age. Two decades ago, Grolier Club President Gordon Ray lamented the lack of interest in collecting books. In contrast to art collecting, he characterized book collecting as "the province of an inconsiderable number of eccentrics, for the most part fighting a losing battle with institutional libraries for esoteric objects that the great public is quite content to ignore."[6]

Larry Longo, a clinical scientist and bibliophile-historian at Loma Linda, recently used some creative analogies to make the same point. He claimed, "As with long-distance running and deep sea diving, book collecting is a somewhat lonely business. Most people do not want to hear about a bibliophile's latest great find. . . . Thus, book collectors, like medieval monks, tend to lead rather isolated lives."[7] The sense of isolation Longo depicted can be eased, however, if collectors included in their circle historians and historical librarians as well as other bibliophiles.

Working together, bibliophiles, historians, and librarians make a formidable team for expanding our knowledge about the medical world of earlier generations.[8] Librarian and historian Walton McDaniel wrote, in 1939, "Our larger medical libraries are swollen with medical literature that is today unknown . . . much of [which] would reward systematic study and analysis by competent medical historiographers. I would defy any such to spend a single hour in the stacks . . . without coming upon a half-

dozen items that would stimulate . . . the writing of a like number of worthwhile papers."[9]

This approach should be used cautiously, however. Bibliophiles and amateur historians must recognize the importance of placing a book in its historical context. Social historians have emphasized the need to consider the economic, political, and other social factors when studying medical history. And these influences rarely are apparent from the study of old texts alone.[10] In 1946, historian Owsei Temkin warned, "The knowledge of old medical books and of their contents does not [alone] give a historical picture of the past. Only when the lives of great doctors, influential opinions and theories, and factual knowledge are so arranged as to appear as links in a process do we have 'historical perspective.' "[11]

While I am not suggesting that all medical collectors dabble in history, I believe that a knowledgeable bibliophile can contribute to scholarship. If, as several writers have claimed, the library is the historian's laboratory, serious book collectors have a resource that should not be overlooked.[12] Many bibliophiles have successfully used their collections as a source of inspiration for important historical studies. A few examples will illustrate this point.

Nineteenth century surgeon Samuel D. Gross's many achievements led historian Fielding Garrison to call him "the greatest American surgeon of his time."[13] This busy practitioner, celebrated teacher, and productive author also was a world-class book collector. Gross recognized the value of focused or thematic collecting—he assembled major subject collections devoted to anatomy, surgery, and urology.

Surely a bibliomaniac, Gross admitted, "Nothing apart from my immediate family has afforded me greater happiness than my library. I have always been passionately fond of books, and have spent money freely on their purchase. The fact is I have more books . . . than I have room for. Bookcase after bookcase has been put up, and yet my books are scattered everywhere over the floor."

Gross's obsession can be excused, perhaps, because he used his library. He wrote a valuable historical survey of America's medical literature and a biography of John Hunter and edited a volume of biographical sketches of prominent American physicians. Gross enjoyed writing as much as he loved books. He admitted, "Many of my happiest days and nights have been spent with my pen, in the silence of my study . . . in the midst of my books."[14]

This rhetoric bears witness to a statement made by Gross's contemporary, Oliver Wendell Holmes. A book collector and student of medical history, Holmes appreciated the intellectual stimulation of a library. He asked rhetorically, "What is the nest that hatches scholars but a library?"[15] A century after Gross's death, it still is possible to see and use his books. His library of several thousand volumes is preserved at the College of Physicians of Philadelphia.

John Shaw Billings, a man of many talents, was another prominent 19th century bibliophile-historian. Besides being America's greatest medical bibliographer, he was an institutional bibliomaniac of legendary stature. Responsible for the development of the surgeon general's library, Billings's appetite for books for the national medical collection was insatiable. Oliver Wendell Holmes warned, "Dr. Billings is a bibliophile of such eminence that I regard him as a positive danger to the owner of a library, if he is ever let loose in it alone."[16]

Billings viewed books and history as inseparable. Officials of the Johns Hopkins School of Medicine acknowledged this in 1893, when they appointed him lecturer in the history and literature of medicine.[17] Billings's historical writings reflected his remarkable knowledge of the world's medical literature. His historical works included a centennial survey of American medical publications and a history of surgery that William Welch considered "the most valuable contribution to the subject in the English language."[18]

Despite his bookish focus, Billings did not view medical history in a narrow, antiquarian sense. He claimed a century ago, "To attempt to isolate the history of medicine, and to comprehend its curious ebbs and flows of doctrine, from medical writings only, is like cutting a narrow strip from the centre of a piece of tapestry and speculating upon the origin and purpose of the cut threads and fragments of patterns that may be found in it." Anticipating the rhetoric of today's social historians, Billings argued that knowledge of the cultural, economic, and political context was necessary if one hoped to really understand the history of medicine.[19]

Some readers no doubt have been wondering when I would get to William Osler. His influence on medical book collectors of the 20th century is hard to exaggerate. Many physicians began to collect medical books or became amateur historians in response to Osler's example.

Osler's interest in book collecting preceded his fascination with the history of medicine, but the two soon became closely intertwined. As the size and quality of his library grew during his years in Baltimore, Maryland, Osler began publishing more historical articles. His classroom exercises and bedside rounds often included a summary of the history of the topic under discussion. When students came to Osler's home, as they did each week, his library was a source of stimulation as books were used to illustrate some point.

Osler was a bibliomaniac who turned his obsession into productive scholarship. For him books

were not simply objects to be accumulated—they were to be used. He wrote dozens of historical and biographical essays, many of which were inspired by books in his collection. Osler encouraged medical bibliophiles to seek "[to] know the books and the lives of the men who wrote them."[20]

Several of Osler's contemporaries at Johns Hopkins shared his interest in books and history. William Welch, William Halsted, and Howard Kelly assembled important collections and participated in the Johns Hopkins Hospital Historical Club. As the pupils and former associates of the original Hopkins faculty spread throughout the country, they carried to other institutions and locales the interest in books and respect for medical history they acquired in Baltimore.

Osler knew that his library had been an inspiration to others during his life, and he wanted this to continue after his death. When he decided to bequeath his magnificent book collection to McGill University, he wrote, "The library [is] to serve ... two functions—the education of students in the history and methods of science and of medicine and to promote research into these subjects."[21] Anyone who has visited the Osler Library in Montreal can attest to the fulfillment of Osler's wish.

One of Osler's most notable protégés was Harvey Cushing.[22] Cushing grew up in a bookish family and was educated at Yale and Harvard before going to Johns Hopkins in 1896 as William Halsted's resident. Although interested in books before he moved to Baltimore, Cushing's exposure to Osler, Halsted, Kelly, and Welch turned him into a bibliomaniac.[23] Cushing, who lived next door to Osler, recalled, "Those fortunate enough to come as latch-keyers under Osler's neighborly influence became inoculated with his bibliophilic spirit."[24]

Cushing designed his bookplate during his first year in Baltimore, and its production signalled a significant increase in book purchases. Like Osler, he was more than a collector; his books were a great source of intellectual stimulation. Cushing told fellow collector Arnold Klebs in 1934, "To love books merely because they are old or rare or expensive seems to me primitive sentimentality ... I want to ponder the very existence of any book, why was it writ, why was it thought, why was it print, why was it sold, why was it bought."[25]

Cushing's most notable historical achievements were his Pulitzer prize-winning biography of Osler and his biobibliography of Andreas Vesalius. Cushing's interest in Vesalius resulted from Howard Kelly's gift to him of the 1555 edition of the *Fabrica.* Speaking of Kelly, Cushing declared, "He has led many a librarian and many a helpless young student into a bibliophilic downfall."[26,27]

Once Cushing possessed this second edition of Vesalius's masterpiece, he wanted to see how it differed from the original edition of 1543. Soon, he sought later editions, and these triggered more questions. Cushing explained, "Vesal[ius] had complained ... of various plagiarists of his earlier anatomical plates; these must therefore probably be of interest. And then the many other authors, his copyists and imitators, and the printing houses which issued their books, and what other medical books they printed, in turn lead you on, with a ring in your nose."[26] Cushing's curiosity and the research it triggered resulted in his definitive study of Vesalius's writings.

Many others have benefitted from Cushing's bibliomania. After a visit to the Osler Library at McGill, he decided to bequeath his 15,000 volume collection to Yale where it has inspired two generations of bibliophiles and scholars.[28,29] According to Cushing, books must be accessible if they are to foster scholarship. He claimed, "I have always felt that a hospital or medical school that wished to cultivate a scholarly spirit must have its library on the ground floor.... Books must be put in the [medical student's] path so that he will stumble over them."[26]

Osler also catalyzed Baltimore ophthalmologist Harry Friedenwald's interest in books and history.[30] As much as any physician ever has, Friedenwald successfully integrated his love of books and his desire to contribute to the history of medicine. His skill as a collector and his accomplishments as a historian are reflected in the catalogue of his library and two volumes of his writings.[31,32] In addition to assembling the world's finest private collection relating to Jewish medicine, he wrote nearly 50 historical papers on the subject.

Owsei Temkin, noting the dynamic relationship of Friedenwald's interests in books and history, claimed, "It was his large collection that stimulated Dr. Friedenwald toward his [historical] researches, and these researches, in turn, stimulated him to increase year by year his riches of manuscripts, incunables, and other books."[33] Historian George Rosen agreed, "A private library such as the Friedenwald collection cannot be developed haphazardly. It requires intelligent collecting based upon intimate knowledge of the field ... He not only loved his books but even more importantly he read them and used them as source materials for historical research."[34] Like the other collector-historians I have discussed, Friedenwald wanted others to benefit from his bibliomania—he donated his unrivaled collection of medical Judaica to the Hebrew University in Jerusalem.

Another bibliophile-historian influenced by Osler, albeit indirectly, was physiologist John Fulton.[35] As a Rhodes scholar at Oxford beginning in 1921, Fulton spent many hours among Osler's books at 13 Norham Gardens where the late Regius professor's

huge collection was being catalogued.

Fulton also was influenced by Geoffrey Keynes, a British surgeon and bibliographer. Keynes's scholarly bibliographies of Thomas Browne, William Harvey, and Robert Hooke were based on his own comprehensive collections of their works. Fulton credited Keynes with establishing "humanized personal bibliography." Keynes did much, Fulton thought, "to transform a dull and dreary subject into an art that is both exciting and highly informative."[17]

Fulton's collecting was more focused than Osler's. He told Arnold Muirhead in 1928, "My purpose is to acquire a reference library that will make me independent of the larger collections while writing a historical treatise of physiology."[36] Fulton's statement implied that his appetite for books was modest—it was not. He collected thousands of volumes, many of them very rare. And, like other bibliomaniacs, he enjoyed the fun of the hunt. Muirhead recalled, "one can picture Fulton getting at those back rows, for he was always a most determined and thorough searcher. No amount of dust or dirt, no precarious ladder and no seeming inaccessibility deterred him. . . ."[37]

A prolific author, Fulton wrote several hundred historical articles. He published comprehensive bibliographies of Robert Boyle, Richard Lower, and John Mayow. Besides his well-known life of Harvey Cushing, Fulton wrote book-length biographies of Kenelm Digby, Benjamin Silliman, and Michael Servetus. Reflecting his occupation as a physiologist, he edited a collection of excerpts from classic works in physiology and wrote a short history of the subject.

Fulton, like most major collectors, acknowledged the critical role booksellers played in helping him build his collection. "Over the years," he wrote, "many distinguished scholars have been drawn into the book trade, and private collectors and great libraries throughout the world owe an incalculable debt to their learning."[17] Fulton's book collection was united with those of Harvey Cushing and Arnold Klebs at Yale to form one of the world's finest medical history libraries.[38]

The UCLA School of Medicine, founded in 1947, a century and a half after Yale Medical College, also benefited from amateur historians. Horace Magoun and John Field, members of the original UCLA faculty, offered an elective course in the history of medicine. They also were largely responsible for hiring Donald O'Malley, a Renaissance scholar who eventually started a graduate program in medical history at UCLA.

Eulogizing O'Malley, Robert Moes recalled, "Books were his tools, and he learned to use them well. His knowledge of rare historical works was increased greatly by his historical awareness of the people involved in these books . . . Donald amassed an unbelievably extensive working library as well as a moderate, but very good selection of rare medical works."[39]

O'Malley knew a great deal about medical books before he joined the UCLA faculty, having served as director of the historical collection at Stanford's medical library. Recognizing the interdependence of books and history, O'Malley worked diligently to develop the medical collection at UCLA. His efforts led urologist John Benjamin, an alumnus of UCLA and a Hopkins medical graduate, to donate his extraordinary collection of medical classics to the institution.[40,41]

It is no coincidence that formal programs in the history of medicine grew up around the book collections at Johns Hopkins, McGill, Yale, and UCLA. Bibliophiles and amateur historians played a critical role in the development of the disciplines of medical history and the history of science during the 20th century.[42] Historian Victor Hilts claimed, "History of science at . . . Wisconsin has developed in some respects as a microcosm of the discipline as a whole. Eminent scientists with a love of rare books and an avocational interest in history led the way."[43] The same can be said for most of America's formal medical history programs.

In 1909, William Snow Miller, a protégé and pupil of Johns Hopkins anatomist Franklin Mall, organized a medical history seminar at Wisconsin. Miller's collection of 6,000 volumes was the focus of this pioneering medical history program.[44] Wisconsin dean and bibliophile-historian William Middleton claimed, "[Miller's] private library supplied the incentive, and in many instances the source references, for study."[45]

Another midwestern institution, the University of Kansas Medical School, became a center of medical history activity because of two bibliophiles—Ralph Major and Logan Clendening. Major, a 1910 Hopkins medical graduate, was imbued with an interest in books and history at the Baltimore institution. He became chairman of the department of medicine at Kansas in 1921, and for half a century inspired an interest in medical history among the school's students and faculty. William Middleton claimed that Major "was largely responsible for the school's remarkable medical library."[46] Major's historical publications included the popular anthology, *Classic Descriptions of Disease*, and a two-volume history of medicine.

Major was assisted in his historical endeavors at Kansas by academic internist Logan Clendening. An energetic collector and prolific author, Clendening, like Major, found his books to be a source of stimulation for historical writing.[47] Major claimed, "As [Clendening's] interest in medical history grew, his

desire to possess the great classics in medicine grew. He soon assembled one of the finest private collections . . . which was at once the despair and envy of his bibliophilic friends."[48]

Beginning in 1924, Clendening taught a medical history course at Kansas. A quarter of a century later, he donated his library to the medical school with the hope it would stimulate historical research.[49] It did. In 1960, Terry Cavanaugh, curator of the Clendening Library, boasted, "In each medical school class a number of students are engaged in historical research based on the collection."[50]

As they encouraged the study of medical history, Major and Clendening also inspired many Kansas physicians to collect medical books. This led Bill Bean to remark in 1962, "Interest in medical history is so active around Kansas City that it is a waste of time to go to a second-hand book store. The medical books are all cleaned out and there is nothing left for the late comer."[51]

Each bibliophile-historian I have mentioned donated their books to a library. Collectors are aware of the unrelenting institutionalization of important books. While this trend may alarm and frustrate bibliophiles and booksellers, it has profound implications for scholarship. Most important institutional collections owe much to the bibliophiles whose libraries were acquired through gift or by purchase. Librarian Evert Volkersz claimed recently, "Many of the major research collections were assembled by private collectors. In the process of collecting they often have opened up new areas for research and scholarship. The curiosity, persistence, and accomplishments of the private collector are, unfortunately, sometimes underrated by the institutional collector, to his or her own detriment."[52]

In a similar vein, Archibald Malloch, librarian of the New York Academy of Medicine, claimed in 1931, "Without someone who has a love of books, the craving to collect, and plenty of energy, libraries cannot be built up."[53] Twenty-five years later, Malloch's successor, Gertrude Annan, advised, "Any library starting to build a useful collection for the historian can do no better with its funds than to obtain collections on one subject already brought together painstakingly and lovingly over the years by a knowing enthusiast. This serves both history and the historian far better than a treasure of expensive highlights with only a high price in common."[54]

Most historical librarians appreciate these concepts. British librarian Roderick Cave proposed recently, "To be good at attracting donations to his library the rare books librarian must . . . combine the erudition of the scholar, the enthusiasm of the lover, and the persuasiveness of the con man."[55]

But has all this institutional collecting fostered scholarship? Historian James Cassidy of the National Library of Medicine thinks so. He claimed, "The increasing numbers of medical society and medical school rare book libraries have . . . contributed to the greatly accelerated production of medical history articles and books in our times."[56]

But what of the future for medical bibliophiles and amateur historians? Nearly half a century ago, Boston neurologist and historian Henry Viets mourned the death of physician, bibliophile, and historian Edward Streeter. Reflecting also on the passing of Osler, Cushing, Welch, and Klebs, Viets declared, "With the development of the professional historian of medicine, the era characterized by the amateur of great scholarship, charm, book-collecting instinct, and long purse has largely passed with the death of the last of a great band of thoughtful men who made distinct contributions to our medical heritage."[57]

Viets would be happy to learn that a few bibliophile-historians are carrying on the heritage of those pioneers. Despite the professionalization of medical history, opportunities for research and writing abound for amateur historians and medical bibliophiles. A greater problem is finding significant medical books.

There are many challenges confronting medical book collectors as we approach the 21st century. But there are also as many opportunities. Of several possible themes, I have selected three: the need for the collector to define a focus for his library; the concept of rarity; and the importance of collecting 20th century items.

Every bibliophile must confront the question of what to collect. The subject and scope of the material brought together determines whether one has formed a collection or has simply accumulated some old books. A common goal of medical collectors of earlier generations was to acquire the great classics of medicine, so-called milestone collecting. This approach, popularized by Osler, today is impossible for medicine as a whole. Even if a collector has the money to buy many of the true classics of medicine, most of them are unobtainable.

In 1958, zoologist and bibliophile Francis Cole reflected on a half century of collecting: "I often think that what I have done in assembling a valuable historical library of some 8,000 volumes can never be repeated under modern conditions . . . [because] the books themselves are rapidly becoming absorbed into university and society libraries . . . [and] book prices have soared out of all reason. . . ."[58]

In view of the scarcity and cost of old medical books, it is important that the collector define a limited number of subjects for his library. There are practical and philosophical advantages to such focused or specialized collecting, a trend that began in the middle of the 19th century.[59] By defining a theme for their library,

bibliophiles can learn about the history of the subject they collect. They should get the relevant secondary sources—the histories, biographies, and bibliographies—that relate to the field. These reference works also will facilitate historical research if the collector decides to use the library for scholarly purposes.

A knowledgeable bibliophile is more likely to assemble a significant library than an individual who buys indiscriminately. Gertrude Annan once noted, "Money is necessary for most collecting but time and expertise are far more necessary."[60] It still is possible for the enlightened and persevering collector to acquire pertinent titles at reasonable cost.

The focus of a collection should reflect the bibliophile's interests as well as the cost and availability of relevant items. In general, physician-bibliophiles should focus their collection on their specialty since they have some familiarity with the recent history of their discipline. When, after all, does a review of the literature end and medical history begin? Formal reading of historical books and articles is necessary, however, if the collector hopes to gain true insight into the development of his field of interest.

Medical collectors need not focus on their specialty, nor must they limit themselves to a single collecting theme. They may decide to collect works dealing with a specific historical period or a defined geographical region. The interfaces of medicine with other aspects of society provide many possibilities for specialized collecting. Examples of this include physician-explorers and physician-authors. Other possible collecting themes are medical education, women physicians, military medicine, and home medical guides—or a new field like medicine in space.

Once the collector has decided that a title belongs in his library, the hunt begins. This is both the fun and the challenge of book collecting. Approaches vary from the collector who haunts flea markets and second-hand book stores to the more reserved bibliophile who buys only from catalogues. Today, the latter method is more efficient because most collectible medical books that come on the market are offered by specialist dealers.

When a collector seeks a specific volume, the main considerations are availability, condition, and cost. Several factors determine whether a book is common, scarce, or rare. The concept of rarity has long fascinated bibliophiles, and the term rare tends to be overused by both collectors and booksellers. John Shaw Billings claimed a century ago: "The term rare as applied to medical books has a relative and not an absolute value. There is no necessary connection between the rarity of a book and its cost, nor between either the rarity or cost and actual interest and value, either historical or practical. The cost of a rare book depends mainly upon whether it is a book that is sought for, that is, in demand by collectors."[61] More recently, Gertrude Annan cautioned, "A major point to remember is that the value of any item in any collection does not depend upon its market value. It is the value of a particular text within the particular collection."[60] I had fun developing a series of aphorisms to amplify the points made by Billings and Annan:

All rare books are not important, expensive, or old.

All old books are not rare, expensive, or important.

All important books are not rare, old, or expensive.

All expensive books are not important, old, or rare.

The more knowledgeable the collector, the greater the likelihood he will be able to sort out these relationships for a specific title. To be sure, all collectors, historical librarians, and booksellers dream of finding books that are rare and important, yet inexpensive.

Medical book collecting continues to evolve in response to many forces in modern society. The demand for old medical books has increased as the number of physician-collectors has grown and as formal programs in the history of medicine have stimulated broader interest in the field. Moreover, books, like antiques and works of art, have become objects for speculation. Medical book prices have increased steadily for several decades.

Martha Gnudi, head of the History and Special Collections Department of the UCLA Biomedical Library, claimed in 1975 that the two principal requisites for building a medical book collection were "specialized knowledge of the field and money. . . . The days of 'picking up bargains' are pretty well over."[62] Today, I would urge the serious collector to reflect on Fielding Garrison's advice if the price of a desired title seems excessive. In 1911, he declared, "Provided one can afford it, the price asked for any good book is seldom too much."[63]

While it is unwise to collect books primarily as an investment, it is true that a knowledgeable bibliophile who assembles a comprehensive subject collection over several years is likely to have a valuable asset. In 1967, Minnesota surgeon and historian Owen Wangensteen claimed, "Those of you who have been collecting old books can appreciate that a dollar invested in a choice item may prove to be as gilt-edged as was a dollar invested in Minnesota mining stock 40 years ago."[64]

Novice medical book collectors may find current market conditions depressing. It is not all that bad, however. As I said earlier, not all important medical works are rare or expensive. Nor are they old. I would like to close with a plea that collectors and librarians rid themselves of the common prejudice against 20th century medical publications. As we approach a new century, in-

deed, a new millennium, I think it is important to reconsider the term "old medical books." Like rare, old is a relative term. Bibliophiles of earlier generations—of Osler's day—collected manuscripts, incunabula, and 16th century books. They were not cheap, but they were available. Today, even 19th century medical books are scarce.

For a variety of reasons many medical collectors have turned their attention to more recent publications. They have reacted to the declining availability and increasing cost of pre-1900 medical books. But, they have also acknowledged the compelling intellectual reasons to collect 20th-century items. Once bibliophiles recognize the value of defining a theme for their collection, they place less emphasis on acquiring books simply because they are old.

Because most medical and surgical specialties emerged during the past century, it is impossible for the collector who focuses on one of these areas to avoid so-called modern works. Today, most American physicians consider themselves specialists. At the same time, most medical bibliophiles collect works relating to their clinical specialty. This combination assures growing interest in 20th century works among medical collectors. Also, in just eight years, these items will be from the last millennium, an encouragement for those collecting 20th-century titles.

Twentieth century works represent a special challenge for collectors and booksellers since, for this period, it often is difficult to distinguish important from insignificant publications. The individual with medical training and knowledge of the history of the subject they collect is best able to recognize significant works. My research in the history of cardiology and my clinical knowledge of the field have helped me decide that 20th century items should be in my collection. Because most diagnostic and therapeutic cardiology procedures were introduced during the present century, it is impossible to ignore recent publications. To collect cardiology and neglect 20th century works is like having a love of flying yet never travelling faster or higher than is possible in a hot air balloon.

Another challenge confronts the collector of 20th-century medicine. Most advances in cardiology, like other specialties, were first reported in journals. Serious collectors of modern medicine and science cannot afford to ignore publications that appeared in this format. And they are not—the interest in periodicals among collectors has grown steadily in recent years.

Journals have been the preferred medium for reporting discoveries for several generations. Historian and librarian David Kronick claimed, "By the last half of the 19th century all of the important [medical] contributions were being printed in journals."[65] A review of the Garrison Morton bibliography supports this claim. Indeed, Leslie Morton recently declared, "Today virtually no vital work makes its first appearance in a book."[66]

So, the individual who hopes to possess the medical milestones of the last 100 years has no alternative but to attempt to obtain periodical contributions in some format. This also is true for collectors who seek the works of specific physicians, many of whom, like William Halsted, published influential articles but no books.

Journal contributions, whether in the form of a single issue, a bound volume, or an author's offprint, are much more difficult to obtain than books. Individual volumes of periodicals rarely come on the market, and when they do they are bulky, contain superfluous material, and usually bear library markings. None of these characteristics appeal to the traditional bibliophile. Morris Saffron, whose name is well known in medical history circles, is a pragmatic collector who assembled an important library now housed at the University of Medicine and Dentistry of New Jersey.[67] He claimed a decade ago, "Granted, periodicals may not be as attractive to look at as a handsomely bound book, but if the paper is important, the journal in which it first appears will become increasingly valuable and saleable."[68]

The most desirable format of periodical contributions is the author's offprint. But these are truly rare—they always have been printed in very small quantities for personal distribution. Bibliographer and historian John Neu observed, "Offprints, by their very nature, are scarce from the day of their printing; they seldom survive the death of their recipient. . . . Not even libraries take trouble to preserve them . . . Certainly after a hundred years, a scientific paper in offprint form is practically unfindable."[69]

CONCLUSION

Medical book collecting continues to evolve. Osler, Cushing, and other great bibliophiles of earlier generations had opportunities that current day collectors do not enjoy. New fields of collecting have emerged, however. To be successful, today's bibliophile must be innovative, persistent, and willing to take the time to become an expert in his chosen collecting area.

Important private libraries are being formed, and amateur medical historians still are contributing to scholarship. ■

References available upon request.

Dr. Fye is chairman, Cardiology Department, Marshfield Clinic, Marshfield, Wisconsin, and is an adjunct professor of medical history and a clinical professor of medicine, University of Wisconsin, Madison. This paper was presented to the Medical History Society of New Jersey. Address reprint requests to Dr. Fye, Marshfield Clinic, 1000 N. Oak Avenue, Marshfield, WI 54449.

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Heirs of Osler: Medical Bibliophiles in America

Morris H. Saffron, MD

An heir is one who appears to acquire a trait from a predecessor or carries on his tradition. The author presents details about the great bibliophiles who received their stimulus from William Osler, his associates, or his writings. William Osler influenced the formation of private libraries in the United States.

Webster states that the word heir is one who appears to acquire some trait from a predecessor or seems to carry on in his tradition. It is in this sense that I present some details about the great bibliophiles who received their initial stimulus in this direction from William Osler, from one of his associates, or from his writings.

It is obvious that collecting rare books in the field of medical history is invariably inspired by a deep interest in the subject itself. Osler took not only the acquisition of rarities but the lessons to be derived from them as a real challenge in his approach to students. As early as 1890, he inaugurated the famous Johns Hopkins Historical Club, which still exists, and which became the prototype for many similar groups that were created throughout the country. Howard Kelly noted that "by the foundation of the Historical Club and by his method of teaching, Osler greatly stimulated interest in the history of medicine in the minds of students and of his colleagues in ways more effective than by systematic lectures on the subject." Kelly shared his own ideas and enthusiasms with Osler and, generous to a fault, he took delight in presenting a valuable book to his friend. His own rare volumes eventually went to Hopkins, but the remainder of his library was dispersed at auction. At meetings of the Johns Hopkins Historical Club that Osler regularly attended (along with fellow bibliophiles Kelly and William Welch), he would invariably bring along a few old volumes with the express intention of stimulating interest among the younger men. John Finney recalls, "Osler was constantly urging his students to develop a hobby, his own being books, old books, especially first editions." He goes on to say how Osler would fairly gloat over some rarity recently acquired. The great historian Sigerist, who regretted never having met Osler, has this to say about the void left when Osler sailed for England in 1905: "But although he was absent in the flesh he remained active in America for his ideas continued to bear fruit among his pupils and his pupils' pupils." Another Baltimorean, Harry Friedenwald sent a great collection of books on Jewish medicine to the Hebrew University in Israel.

It is an error to assume that serious medical book collecting in this country began with Osler. The doctor and his library have been inseparable from time immemorial. In 18th century England, one can recall such great collectors as Hans Sloane, Richard Mead, and Anthony Askew. Over 100 American physicians who flourished before 1820 had considerable book collections in which they took pride. Mid-19th century Philadelphia saw the rise of three important collections formed by Joseph Carson, William Kent Gilbert, and Samuel D. Gross, the great surgeon. Incidentally, it was the latter's son whose widow was to become the wife of William Osler and mother of his only son, Revere. Osler must have known the Carson and Gross collections, both of which were donated to the College of Physicians and Surgeons of Philadelphia. In the 19th century, Osler's friend, Joseph W. Toner, the medical historian of the American Revolution, amassed an enormous collection of 27,000 volumes that eventually was given to the Library of Congress, and as did Oliver Wendell Holmes, the Boston poet-physician, whose admirable collection is housed in the Countway Library at Boston. Osler undoubtedly was familiar with many of these earlier collections as well as with the libraries of fellow Charakans, including Charles L. Dana, S. Weir Mitchell, and the third president

of the Charakan Club, Lewis S. Pilcher of Brooklyn, whose superb collection of medical classics eventually was bequeathed to his alma mater, the University of Michigan. It is Mitchell, the noted Philadelphia neurologist-novelist, who is credited with having encouraged Osler in his first serious steps as a medical book collector. Nor should we overlook the close friendship that existed between Osler and the great medical bibliographer John S. Billings, the originator of the famous *Index Catalogue.* Billings was succeeded at the Army Medical Library by Fielding Garrison who, though much younger than Osler, developed close ties with him. Other friendly historian book collectors included Francis R. Packard and James G. Mulford.

It should be noted that the collecting of medical books was not always held in high regard by literary men. Charles Dibdin, the early 19th century bibliographer who popularized the term 'bibliomania' once wrote, "I don't see why the librarians allow medical books to remain on their shelves." More recently, A. Edward Newton, author of many books on collecting, and the man who is supposed to have done more than any other individual to encourage the art in America, had the audacity to say, "I can't see how anyone collects medical books."

John Ruhrah of Baltimore described Osler's keen interest in the bookish interests of his many friends: "For the book lover, the bibliophile, he had the affection of a brother. There were few of any prominence that were not his warm friends, and he did much to induce them to make a practical use of their predilection and knowledge." Ruhrah cites as an example of such encouragement Eugene F. Cordell's scholarly *Medical Annals of Maryland,* but he might have cited his own *Pediatrics of the Past,* C.N.B. Camac's *Imhotep to Harvey,* David Riesman's *Medieval Medicine,* and Edward B. Krumbhaar's series of books, *Clio Medica.* The latter, a sophisticated collector, recalls the keen interest Osler took in the famous library of the College of Physicians and Surgeons. W.W. Keen, who bought a number of rare books for that institution, noted that Osler continued to send fine gifts even during his Baltimore and Oxford periods. Another library that benefitted greatly from the activities of an Osler disciple was that of Hartford County Medical Society, owning much of its strength to the efforts of Walter R. Steiner, a fellow Charakan and great collector.

However, it was in the Baltimore period that Osler, spurred by fellow collectors Welch and Kelly, began to think seriously about forming a great library to illustrate and fortify his strong historical interests. Welch noted that "Osler's historical and bibliographical knowledge was far more than a mere recreation or even a cultural embellishment. They constituted an essential part of his rich equipment as an inspiring teacher and student of medicine." Llewelyn F. Barker states, "And, in our own little libraries what books are more cherished than those that came as gifts from him? I prize my folio *Vesalius* the more because of the way it came to me." Thomas R. Boggs, wrote of "feeble attempts to follow in his steps as a collector." Unlike many collectors, Osler was capable of lending valuable books from his library freely and ungrudgingly. And in every city that he came to call home during his long career, he took delight in frequenting and supporting medical libraries. Thus, in Baltimore he effectively resurrected the long neglected library of the Medical and Chirurgical Faculty of Maryland, not only by his enthusiasm but more practically by the donation of many books.

Now primus inter pares among the bibliophilic heirs of Osler, without question, was Harvey Cushing, a member of a Cleveland family of physicians who over a period of several generations had cherished and augmented their libraries. Osler and Cushing developed and sustained a friendship of great closeness for a period of 23 years, beginning in Baltimore and ending with Osler's death. Although differing markedly in temperament, they were similar in their passionate attachment to book collecting and medical history. Cushing's identification with Osler was such that at least in many of the activities of his latter years he is said to have represented in effect an extension of Osler's presence. Cushing speaks of himself as "being inculcated with the bibliophilic spirit which has proved a solace for many of us in our later years" and once described book collecting as "worse than the opium habit, but much more fun," and "as a slowly progressive though rarely fatal malady." Yet, in his famous biography of Osler, now regarded as second only to Boswell's *Life of Johnson* as pure literature, it is remarkable how little space he allotted to the love of books, the principal tie that united them over so many years. When Cushing died in 1939, he bequeathed his entire collection of 20,000 volumes, especially rich in Vesalius, Pare, and Jenner, to Yale University.

Second in the Yale "Trinitarians," as they sportively called themselves, was Arnold C. Klebs, whose father Edwin was the codiscoverer of the diphtheria bacillus, and who met Osler as a Hopkins student when his family migrated to this country. Klebs was not simply an accumulator of rare books but considered his library as a "laboratory in which the thought and achievement of the past would be properly utilized and applied for a broader attack on medical problems." His checklist of scientific and medical incunabula is useful, and his own collection of this material joined Cushing's at his death in 1943.

The third and youngest member of the Yale group was John F. Fulton who never met Osler, but knew Cushing so intimately that he later became his official biographer. Fulton, who had the privilege of living with Osler's books at Oxford for several years wrote, "Although I never knew Sr. William personally, he remains for me, as for many others, a living voice. I think that he has influenced my life more than other mentor." A professor of physiology, Fulton collected widely in this field, bringing to the Yale library many classics that were lacking in the earlier collections. When I was working on *Maurus of Salerno* I met Fulton in the famous long room, and he gave me a personal tour, pointing with especial pride to the many original manuscripts that graced that overpowering collection.

Still another Oslerian, Joseph C. Trent married into the Duke tobacco family, and began collecting books in the master's manner to illustrate the main line of development of a subject. Becoming interested in local medical history, he published extensively in the *Medical Journal of North Carolina.* Trent, also a Charakan, already had collected a notable library of 5,000 volumes when, at the age of 33, he died. The Trent Room at Duke University is a fitting memorial to his prowess as a collector.

H. Winnett Orr, the well-known orthopedic surgeon, focused his collecting interests on his own specialty; his collection is a part of the library of the College of Surgeons of Chicago. Orr, who had met Osler in Europe during Word War I, made the illuminating statement: "Even without the numerous references contained in my own catalogue my great debt to William Osler and to his *Bibliotheca* would still be apparent. I have been given great help and constant inspiration from my visit to the Osler Library at McGill in 1933."

Another Hopkins man who was strongly influenced by Osler was Lawrence Reynolds of Alabama who recalls that even before entering medical school he had been given four books on the history of medicine by his father, thus, encouraging a lifelong interest in the subject. As a resident at Peter Bent Brigham, young Reynolds came close to Harvey Cushing, who was then working on his *Life of Osler,* which he was enabled to read in proof. Already stimulated in his zeal for collecting, his books were to become his "vicarious children," which he made available to friends, demonstrating a quality not always possessed by bibliophiles. His library, collected over a half century, eventually was bequeathed to the University of Alabama, which issued a splendid catalogue of the 5,000 volumes.

Other collectors who were encouraged directly or indirectly by Osler include the pediatrician Abraham Jacobi of New York, the Chicago ophthalmologist and bibliographer Mortimer Frank, the Kansan Logan Clendening, LeRoy Crummer, Rudolph Matas of Tulane, John Martin of Iowa, Owen H. Wangensteen of Minnesota, Casey A. Wood, the Montreal ophthalmologist, and George Dock, an intimate of Osler.

With due apologies to the many collectors not included in this paper, I pay tribute to three New York Charakans of distinction in this field. Samuel W. Lambert, coauthored the classic book, *Three Vesalian Essays,* to accompany the publication of the original woodcuts designed by Calcar after Titian for the 1543 *Fabrica.* Lambert purchased the medical book collection formed by Edward Clark Streeter, and both collections eventually were presented to the New York Academy of Medicine by his son, Samuel W. Lambert, Jr. Jerome P. Webster, who studied at Hopkins, was a true bibliophile as well as a scholar. His famous collection on plastic surgery now is in the College of Physicians and Surgeons.

CONCLUSION

I quote from the remarks of a fellow Charakan Francis S. Packard, dean of American medical historians: "Osler was more than a great physician. In bibliography which he termed his recreation, he achieved the highest honors and to him more than to any other person is due the stimulation which has induced many physicians of late to take up the study of books and their authors." Since Packard made this statement many years ago the medical book collecting fury has intensified so that one bookseller recently estimated that there are at least 5,000 physicians in this country for whom collecting has become an important part of their life. He added, however, that of this company only a mere 50 could claim the proud title of belonging to that elitist class which according to Osler himself, "the profane call bibliomaniacs, men who keep alive the sentiment of historical continuity in the professon."

One cannot underestimate the pervading and unending influence exerted by this remarkable man on the formation of private libraries in this country, many of which have come to rest in splendor in our many academies and universities. ■

Dr. Saffron is archivist-historian for the Medical Society of New Jersey.

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CLIA-88 Final Rule: Part 3

Kathleen Voldish, CLA (ASCP)

Physicians performing laboratory tests must have a registration certificate as of September 1, 1992. To continue testing without this certificate could lead to large fines and possible prosecution. This article covers quality assurance, quality control, and maintenance of instruments.

Physicians performing laboratory tests now must have a registration certificate or stop their testing services. To continue testing without this certificate could lead to large fines and possible prosecution. Part 1 of this series covered complexity levels, personnel standard, and types of certificates. Part 2 dealt with sanctions, inspections, and proficiency testing. This final part will cover quality assurance, quality control, and maintenance of instruments.

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Daily quality control (QC) on tests performed in a physician office laboratory (POL) often is overlooked. A 1988 survey conducted by an American Society of Clinical Pathologists (ASCP) committee found that less than 10 percent of pediatricians and family practitioners ran QC daily.

POLs performing only waiver tests can follow the manufacturer's recommendations for controls. This information is contained in the manufacturer's insert that comes with the testing product. Control results should be logged and retained for two years.

POLs performing moderate complexity tests must follow, at minimum, the manufacturer's instructions. For qualitative tests, e.g. mono, quick step, serum pregnancy, the laboratory will need to run a positive and negative control with each run of patient specimens. For quantitative tests, i.e. glucose, cholesterol, CBC, the laboratory must include at least two samples of different concentrations of either control materials, calibration materials, or a combination of both. If control or calibration material is not available, the laboratory must have an alternative method to periodically validate test results, i.e. send the specimen to reference laboratory for confirmation of results. Control samples must be tested in the same manner as patient specimens. All results must be logged. This log must include information such as the lot number, expiration date of the control, and the mean or target value of the control. Control results must be acceptable before reporting patient test results.

Some general QC requirements for moderate complexity tests are being phased in due to lack of control material available from the manufacturer. Until the manufacturers can meet the QC guidelines established by CLIA, the user must follow the existing manufacturer's QC requirements. As of September 1, 1994, manufacturers of FDA-cleared tests must provide the materials needed to meet the full QC recommendations of the standard.

Laboratories doing "high complexity" tests must follow all QC requirements as defined in the standard. QC requirements should be included for each test procedure found in the technical section of the laboratory procedure manual. A general outline of QC requirements is part of the office quality assurance plan. Sometimes QC requirements include inspection of materials for contamination or deterioration, e.g. media plates. The POL must develop a written policy to be followed when controls are out of range and remedial action plans to be followed if the test system does not meet the established performance criteria.

QUALITY ASSURANCE/ PATIENT MANAGEMENT

Quality assurance (QA) is the process of assuring that all testing services involved in the delivery of patient care have been performed appropriately. The sources of potential laboratory errors are many. QA protocols make it possible to identify systemic sources of errors that can develop during the testing process. Patient

test management is part of a QA plan. All moderate and high complexity laboratories must develop written policies and procedures for preparation of patients, specimen collection, specimen labeling, and specimen preservation. Conditions for specimen transportation must be documented in the laboratory procedure manual. Laboratories must use acceptable methods for test requisition, e.g. written in the patient's chart, requisition slips, electronic requisitions. The laboratory must keep an accession log with all relevant information on tests ordered. The test results must be entered into the patient's chart and a copy must be maintained in the laboratory.

Policies should be in practice to monitor and evaluate the ongoing and complete quality of the total testing process, including quality control policies; monitoring of proficiency testing results and corrective action if there is a problem; comparison of different methodologies or instruments performing the same test in one office, e.g. glucose meter and chemistry instrument glucose; communication protocols; and a system to assure that all complaints and problems are documented and investigated.

EQUIPMENT MAINTENANCE

The laboratory must have adequate size and environmental conditions for testing equipment. The laboratory must have adequate reagents, materials, and supply areas. Refrigerator and freezer temperatures must be monitored if used to store reagents, test kits, or patient specimens. Incubator temperatures and water bath and instrument temperatures must be monitored if tests are temperature dependent, e.g. cultures, protimes. Instruments must be calibrated according to manufacturer's recommendations or a minimum of every six months. Calibrations must be documented, and this documentation must include the lot number, acceptable limits, results of calibration, and control verification after calibration. A laboratory introducing a new test procedure must demonstrate the accuracy of the test with instrument verification methods. This must be done before the laboratory can perform the new test. Test procedures that were in place before September 1, 1992, do not require verification or establishment of performance specifications.

All preventive maintenance recommendations from the manufacturer must be followed and documented. All instrument problems and corrective action must be documented. After any major adjustments, controls must be run to document that the adjustment was performed correctly. Maintenance protocols are part of the laboratory procedure manual.

Final CLIA-88 standards are very favorable to the physician who performs tests in his office. In many ways the standard is less stringent than the CLIA-67 standard that has regulated hospital and clinical laboratories. Most of the requirements are good laboratory practices, and have been followed by larger laboratories for years. These protocols work. They enhance the accuracy and precision of test results. Documentation is the key to meeting this standard. Once the POL establishes these protocols, documentation will become second nature. ■

Ms. Voldish is a registered technologist, laboratory manager, and POL consultant. The paper was submitted in May 1992 and accepted in June 1992. Address reprint requests to Ms. Voldish, POL Consultants, 1150 Concord Drive, Haddonfield, NJ 08033.

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Case Report: Malignant Mesenchymoma of the Mediastinum

Randah Al-Kana, MD
Anis F. Rangwala, MD
Charles Sills, MD
Albert Rienzo, MD

Malignant mesenchymoma is a malignant tumor arising in the soft tissues of the body. It is a rapidly growing tumor prone to recurrences and occasional metastasis. It occurs at all ages and locations but has a preference for the extremities and the retroperitoneum.

Malignant mesenchymoma is an interesting malignant tumor arising in the soft tissues of the body. It has been described by Gilmour[1] and Stout[2] as a neoplasm formed of two or more unrelated mesenchymal components, disregarding the fibrous component that usually is present.

Malignant mesenchymoma is a rapidly growing tumor prone to recurrences and occasional metastasis.[2-4] It occurs at all ages and locations but has a preference for the extremities and the retroperitoneum. Mediastinal malignant mesenchymoma is very unusual and only a few cases have been reported.[5]

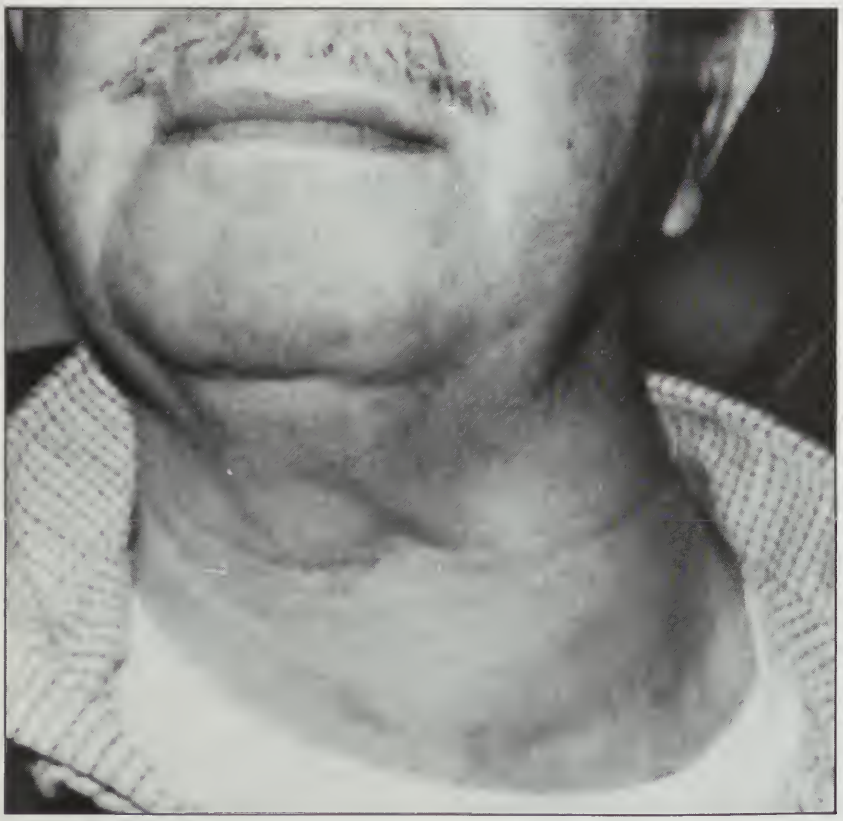


Figure 1. A photograph of the patient showing a large mass in the left side of the neck.

The prognosis usually is related to the prevalent mesenchymal component, hence, survival varies substantially from case to case; it is best with predominantly liposarcomatous neoplasm and least favorable with tumors having a prominent rhabdomyosarcomatous component. Therefore, the predominant and least differentiated histological component is decisive in selecting the mode of therapy.[6]

CASE REPORT

A 67-year-old white male presented in December 1989 with a large mass in his left neck (Figure 1) associated with dyspnea and palpitation. The mass was noted approximately two months prior to his visit to the physician. This mass was described as gigantic, firm, and compressing the trachea. Aside from the tumor mass, physical examination was within normal limits.

Approximately 17 years earlier, in February 1973, the patient was operated on for a malignant tumor of his anterior mediastinum; the tumor was 19 cm in diameter. Bone marrow and left scalene lymph node biopsies were negative for metastasis. Postoperatively he had received a course of radiation therapy to the mediastinum for a total of 6,000 rads.



Figure 2. Chest x-ray taken in December 1989 showing a large tumor in the anterior mediastinum.

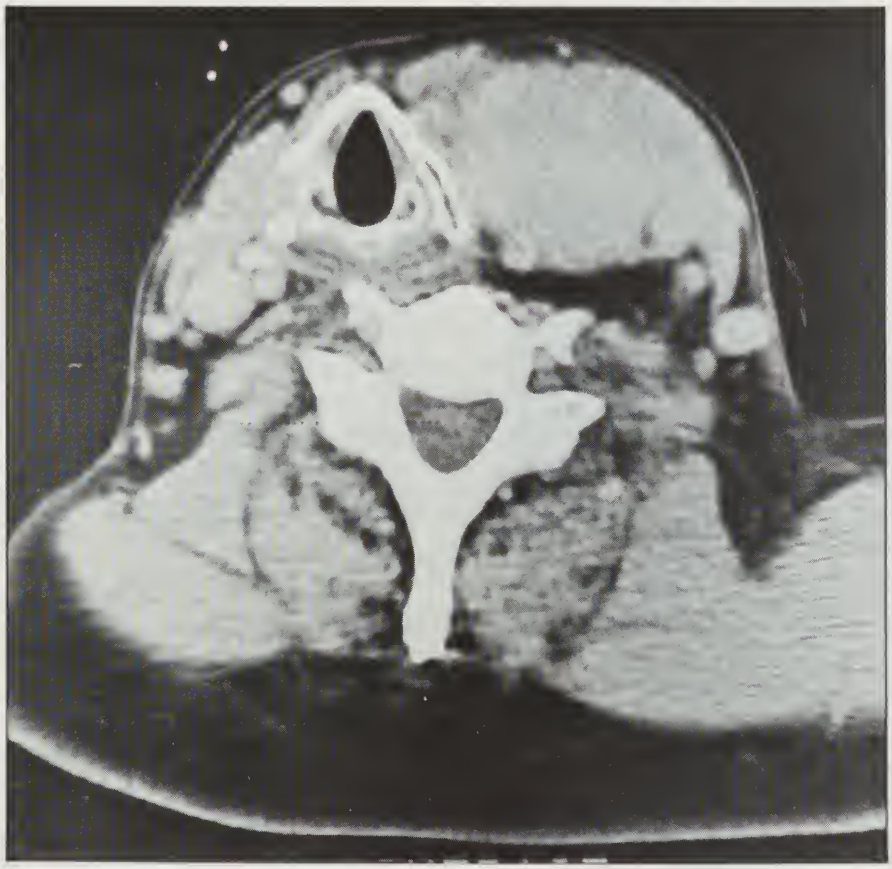


Figure 3. CAT scan of the neck taken in December 1989 showing the mass deviating the trachea to the right.

The patient was followed regularly until the end of 1977 without significant clinical or radiological changes.

RADIOLOGIC EXAMINATION

Ultrasound of the neck demonstrated a large mass in the left lobe of the thyroid measuring approximately 5.3 cm. It was multicystic in appearance.

The chest roentgenogram showed a large, anterior mediastinal mass measuring approximately 26 x 17 x 15 cm. The cardiac silhouette and pulmonary vasculature were within normal limits. There was no evidence of pulmonary infiltrates (Figure 2). Scans of the chest and neck demonstrated a mass in the left neck displacing the trachea from left to right that appeared extrinsic to the thyroid gland (Figure 3).

Partial surgical excision of the mass was carried out through a modified left radical neck dissection. His postoperative course was uneventful. The patient received another course of radiation therapy to the left neck for a total of 5,000 rads and is followed regularly by his physician. The postradiation chest x-ray showed residual densities in the mediastinum.

GROSS EXAMINATION

The entire specimen received in February 1973 was composed of two well-circumscribed lobulated masses with different textures; one was described as tan, soft, fleshy, and homogenous measuring 5 x 3.5 x 2.5 cm. The other mass was firm, yellow, and irregular measuring 19 x 10.5 x 5 cm. The specimen received in December 1989 was a well-circumscribed tan mass (Figure 4) measuring 8.5 x 7 x 4.5 cm.

HISTOLOGIC EXAMINATION

The histological examination of the mass resected in 1973 showed variable histology. Some areas had features of well-differentiated liposarcoma with many irregular

lipoblasts that showed hyperchromatic, eccentric nuclei and vacuolated cytoplasm (Figure 5A). Other areas showed features of malignant fibrous histiocytoma (storiform and pleomorphic subtypes) (Figure 5B). It appeared hypercellular with spindle cells arranged in short fascicles in cartwheel and in storiform patterns around slit-like vessels. Areas of myxoid changes also were noted. However, the malignant fibrous histiocytoma was the predominant pattern.

The tumor resected in 1989 showed a very similar histologic pattern (Figure 5C). Immunoperoxidase for S-100 protein, desmin, myoglobin, and muscle-specific actin were carried out and they were all negative. The objective of performing immunoperoxidase was for academic purposes only, to discover the neural and/or muscular differentiation of the tumor.

DISCUSSION

In 1943, Gilmour coined the term malignant mesenchymoma for mesenchymal tumors consisting of two or more types of distinct tissues.[1] In 1948, Stout described his first eight cases of malignant mesenchymoma, enumerating the criteria of malignant mesenchymoma as a malignant tumor showing two or more unrelated, differentiated tissue types in addition to the fibrosarcomatous element.[2] Stout applied this term to a wide variety of neoplasms, and collected 335 cases of malignant mesenchymoma by 1959. According to Enzinger and Weiss, this tumor is rare and little additional information is in the literature.[6]

The histogenesis of malignant mesenchymoma remains uncertain, though the majority of these tumors occur in older patients. Nash and Stout reported their experience with 42 malignant mesenchymomas in children including 8 patients that, contrary to early definition of malignant mesenchymoma, had an undifferentiated sarcoma as the second element.[7] As the majority occurred in elderly people, it seems highly unlikely that they represented dysontogenetic tumors and were derived from displaced predetermined and partially differentiated mesenchymal elements. It seems that the tumors are derived from primitive and uncommitted mesenchymal elements that have differentiated along multiple cell lines. There is little evidence of any relationship between anatomical location of the tumor and the type of differentiation. It is not known whether any environmental or genetic factors may play any significant role in the determination of the tissue structure and composition of malignant mesenchymoma. The largest series of retroperitoneal mesenchymoma were published by Vayre.[8] He described his experience from 1961 to 1977 with 19 cases. This study points out the salient features of mesenchymomas—the bulky presentation, the histopathology, and the poor prognosis. Of the 19 patients, 1 patient survived eight years; there were 3 patients who survived for five years. Fourteen patients died within a two-month to three-year period. Vayre concluded that



Figure 4. A gross photograph of the tumor removed from the neck in December 1989.

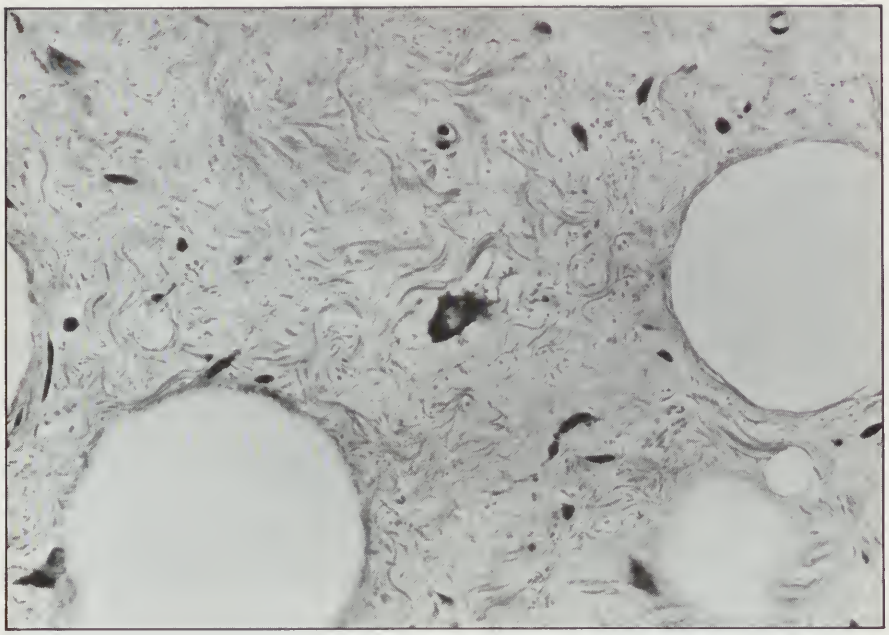
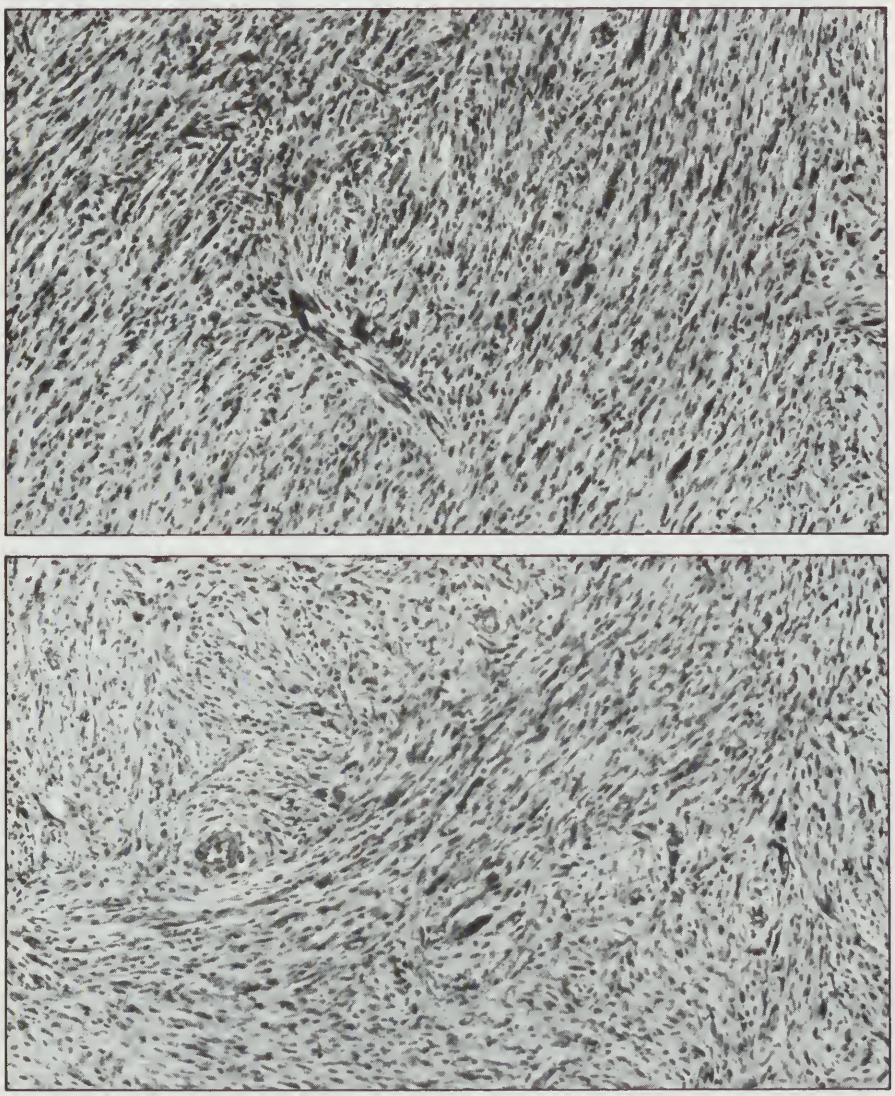


Figure 5A. Liposarcomatous type of malignant mesenchymoma showing a typical lipoblast in the center taken in 1973 (x 400).



Figures 5B and 5C. Malignant fibrous histiocytoma component of malignant mesenchymoma showing similar histiologic pattern in 1973 and 1989, respectively (x 100).

surgery is the optimal treatment modality because radiation therapy and chemotherapy were uniformly ineffective, and stressed that at the first operation one should, if feasible, aim for the widest possible resection. Sharma published a short series of retroperitoneal mesenchymomas comprising 4 patients.[4] All of these patients died within 24 months. Radiotherapy and chemotherapy had a very short-lasting response with subsequent increase in tumor size. A recent review of 400 cases of soft tissue sarcomas by Krementz includes 4 cases of mesenchymoma.[9] Their specific locations, however, were not given. One patient was still alive at five years. No specific treatment was given other than that for soft tissue sarcomas in general. The authors discussed the potential usefulness of combination adjuvant chemotherapy, intra-arterial chemotherapy, external radiation therapy, interstitial brachytherapy, and hypothermic perfusion.

CONCLUSION

There is no accumulated experience or consensus that establishes the most effective treatment for malignant mesenchymoma. The survival rate of patients with malignant mesenchymoma still is uncertain and varies from case to case depending upon the most predominant histologic pattern, which, in our case, was malignant fibrous histiocytoma. However, in our case, this tumor behaved in a very low malignant fashion with a long-term symptom-free interval of 17 years. Although this patient had recent recurrence, it appears that the tumor was well controlled by surgery and radiation therapy. In our opinion, the authors consider this case to be very unusual in terms of location and behavior. The only other reported case of malignant mesenchymoma in the mediastinum was described in 1963.[5] The long-term survival in our case does not reflect the expected aggressive behavior of

malignant fibrous histiocytoma. We have found no previous reports of mediastinal malignant mesenchymoma with a long-term survival. ■

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Drs. Al-Kana and Rangwala are affiliated with the Department of Pathology, Dr. Sills is affiliated with the Department of Thoracic Surgery, and Dr. Rienzo is affiliated with the Department of Ear, Nose, and Throat, Monmouth Medical Center.

The paper was submitted in January 1992 and accepted in March 1992.

Address reprint requests to Dr. Al-Kana, Monmouth Medical Center, 300 Second Avenue, Long Branch, NJ 07740.

Profiles in Medicine: Tribute to Oscar Auerbach, MD

Lenny Saltzman, MD

He is prepared to lecture on lung pathology. Instead, Dr. Oscar Auerbach discusses the role of the physician in society and what tremendous contributions each student has the potential to make. This speech re-energizes second-year medical students every year.

Second-year students at UMDNJ-New Jersey Medical School, Newark, feel overworked and overtired. They are questioning their ability to make it successfully through medical school, and some are questioning their decision to attend. They are chapters behind in their studies, they are financially strapped with the debt of student loans, and they do not see any light at the end of the long tunnel of medical training.

Sometime during this awful period, an elderly man, hunched over and walking slowly and deliberately, reaches the front of the room to address the class.

He is prepared to lecture on the topic of lung pathology, a subject for which he has gained national and international prominence. Instead, he begins to talk about what it means to be a doctor. The room is silent as Oscar Auerbach, MD, discusses the role of the physician in society and what tremendous contributions each individual in the room has the potential to make. As he speaks, the students begin to remember why they chose to attend medical school and, one by one, the students become re-energized and enthusiastic. Dr. Auerbach has provided the extra push so many had needed.

As every graduate of New Jersey Medical School knows, it is more the man than the message that inspires the students to continue working toward their goals. Dr. Auerbach is a living legend to the students, but, astonishingly, many students are unaware that Dr. Auerbach is more than a teacher of pulmonary pathology. Few individuals have contributed more to medicine than Dr. Auerbach. In his 63 years as a physician, Dr. Auerbach has achieved unparalleled success, and at the age of 86, he shows no signs of slowing down.

Dr. Auerbach traces his interest in medicine to the influence of his family doctor. In 1929, his dream was fulfilled when he earned his medical degree from New York Medical College in New York City. He completed a residency at Morrisania Hospital, in New York, and then was influenced by Robert Gross, MD, a prominent cardiologist, to complete a fellowship in Vienna. In Vienna, Dr. Auerbach realized his deep-rooted interest in pathology; he gave up his desire to pursue cardiology to continue to study pathology. It also was in Vienna that Dr. Auerbach met his wife, Dora.

Dr. Auerbach returned to the United States in 1932 and accepted a position at Sea View Hospital in Staten Island, New York. Sea View Hospital was the largest sanitarium in the country, and it was there that Dr. Auerbach first attracted worldwide attention for his work. Although tuberculosis previously had been studied intensively, Dr. Auerbach made important discoveries in the pathology and chemotherapy of the disease. He is partly responsible for the advances that allowed the disease to be successfully controlled at the time. In his 12 years at Sea View Hospital, Dr. Auerbach published over 40 papers. In 1944, Dr. Auerbach accepted a position at Washington University in St. Louis as a visiting instructor.

After two years in St. Louis, Dr. Auerbach joined the Navy and began a lifelong commitment to his country and its veterans. He went to St. Albans Hospital in New York and then to the Veterans' Administration Hospital in Staten Island, where he worked and taught until 1952. In 1952, Dr. Auerbach moved to New Jersey and accepted a position at the Veterans' Administration (VA) Hospital in East Orange. Here he began the studies that would leave an indelible mark on the medical world and society.

Responding to two separate epidemiological reports linking

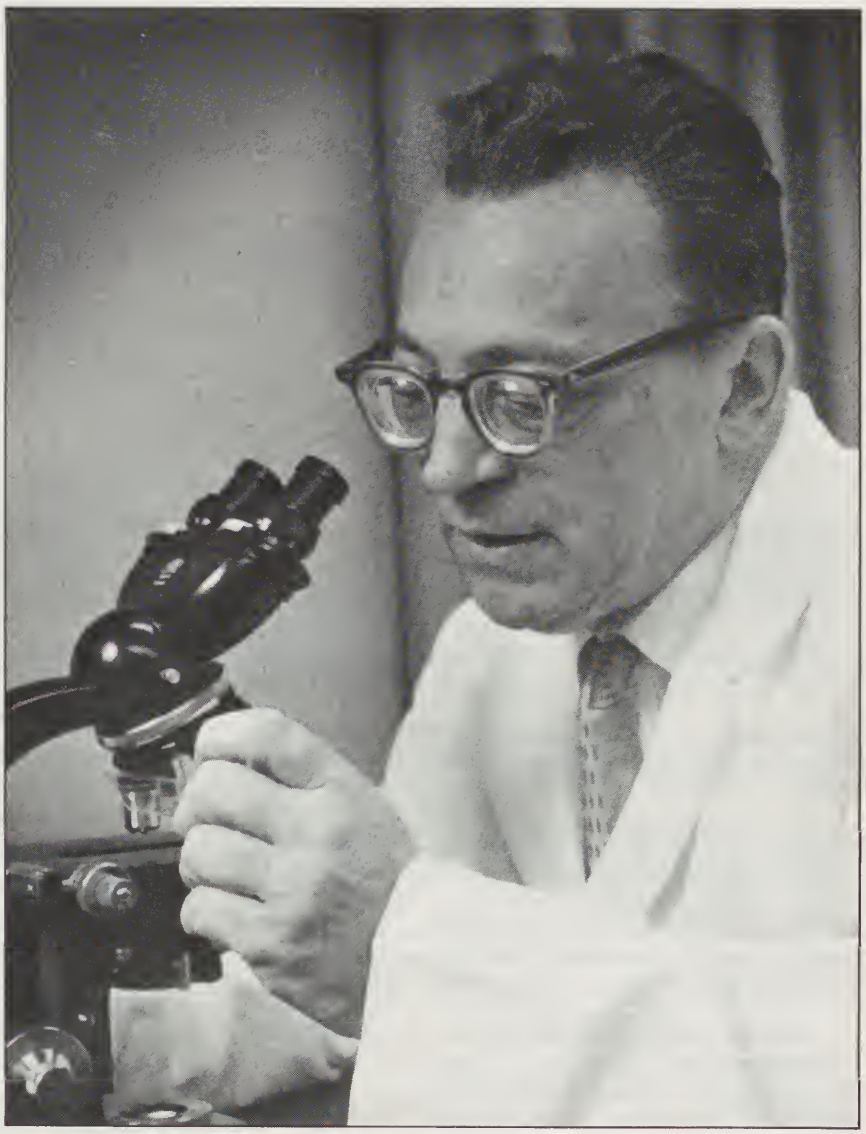
tobacco smoking to lung cancer, Dr. Auerbach studied this question from a pathological perspective. His results, which became the basis for the historic 1964 surgeon general's report, illustrated conclusively the link between smoking and lung cancer, and established the evidence for the causal effect of smoking with emphysema and bronchitis.

Commenting on Dr. Auerbach's revelation, Dr. J. Burns Amberson, the dean of American pulmonary disease, said, "His focus on the problem has been sharp and telling. His perseverance has been exceptional, and his evidence for conclusions has been very convincing. No one has duplicated the task at such length and probably never will."

Similarly, Dr. L. Fred Ayvazian, chief of the pulmonary section of the VA Hospital stated, "Dr. Auerbach pioneered the animal and human research that established conclusively and to the surgeon general's satisfaction the association between cigarette smoking and bronchitis, emphysema, and lung cancer. More than any other physician and scientist, Dr. Auerbach is responsible for currently held views regarding the hazards of cigarettes and industrial pollution."

Dr. Auerbach's studies continued despite great risk to him and his family. The tobacco companies undertook tremendous efforts to refute Dr. Auerbach's work. Also, he found himself the victim of threatening telephone calls and heckling when he spoke about his findings.

Tremendous perseverance and deep love for medicine kept Dr. Auerbach going. He still continues a rigorous work schedule and has published over 150 papers. Dr. Auerbach attends every pathology lecture for second-year students, and is a regular participant at morning reports for internal medicine. Dr. Auerbach sheepishly admits, "My last vacation was about 30 to 35 years ago. I went to Miami Beach, but I had to return early. I did not enjoy it."



Dr. Oscar Auerbach

Dr. Auerbach has received numerous awards and honors in his career, highlighted by the prestigious Trudeau medal, given annually by the American Lung Association for "the most meritorious contribution to the cause, prevention, or treatment of lung disease." Just as significant to Dr. Auerbach are the 15 Golden Apple awards he has won for teaching excellence at New Jersey Medical School.

When recounting his accomplishments and successes, the question of retirement always arises. Dr. Auerbach cringes at the very thought, "My sons have only one fear, and that is that I might some day retire. God, what would I do if I ever retired. I can't do 'nothing' for any extended period of time. . . . No. I could never retire."

For now, it appears that Dr. Auerbach will continue to do research and teach medical students. And as the years pass, young physicians will look back fondly at the motivation provided by a stooped, elderly man at a time when his words meant everything to them. And, in a second-year lecture hall, Dr. Auerbach will be providing motivation to another group. ■

Dr. Saltzman is completing a residency program. He was the 1991-1992 student member of the Committee on Publication, MSNJ. The paper was submitted in May 1992 and accepted in August 1992. Address reprint requests to Dr. Saltzman, 5841 Darlington Road, Apt. C3, Pittsburgh, PA 15217.

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Mental Retardation, Governor's Council on the Prevention of
(Appointed by the governor—June 22, 1984)

Stanley S. Bergen, Jr, MD ..... Newark

Nursing Advisory Committee, New Jersey State Department of Health
(Representation requested by New Jersey State Department of Health—1988)

Ralph A. Skowron, MD ..... Cherry Hill

Osteopathic Physicians and Surgeons, New Jersey Association of
(Invitation to attend Board meetings extended to MSNJ president—July 24, 1986)

William E. Ryan, MD ..... Pennington

Pharmaceutical Assistance to the Aged and Disabled Advisory Council
(Appointed by commissioner of the New Jersey State Department of Human Services—physician representation requested by Division of Medical Assistance and Health Services—December 19, 1980)

Frank J. Malta, MD ..... Toms River

Pharmacopeial Convention, The United States
(Delegate authorized to be seated—August 1988)

Joseph N. Micale, MD ..... North Bergen

Primary Care Task Force for State Health Plan, New Jersey State Department of Health
(MSNJ representation requested by commissioner of health—February 9, 1992)

David E. Swee, MD ..... New Brunswick

Radiation Protection, Advisory Committee on Nuclear Medicine to New Jersey Commission on
(Consultants in nuclear medicine appointed by Commission—November 20, 1966)

Henry J. Powsner, MD ..... Princeton

Radiation Protection, Ad Hoc Committee on Educational Project of the Commission on
(Appointed by Board of Trustees—November 20, 1988)

Carl Restivo, Jr, MD ..... Wayne

Resolutions, Committee on Annual Meeting
(Established by Board of Trustees, July 18, 1971, to review emergency resolutions in advance of the Annual Meeting)

Paul J. Hirsch, MD, *Chairman* ..... Bridgewater
Douglas M. Costabile, MD ..... Murray Hill
Joseph A. Riggs, MD ..... Haddon Heights

Safety Council, New Jersey State
(Provided in Council Bylaws—1962)

William E. Ryan, MD ..... Pennington

Society for the Assistance of New Jersey Physicians and Their Families, The
(Liaison requested by Society—May 17, 1959)

David I. Canavan, MD ..... Lawrenceville

State Board of Medical Examiners
(Member of MSNJ executive staff to attend monthly meetings—per Board of Trustees, August 8, 1979, and September 15, 1991)

Louis L. Keeler, MD ..... Haddon Heights
Neil E. Weisfeld, JD, MSHyg ..... Lawrenceville

Tuberculosis Workgroup, New Jersey State Department of Health
(MSNJ representation requested—February 19, 1992)

Richard C. Laucks, MD ..... Haddonfield

UMDNJ, Foundation of the
(MSNJ representative appointed yearly by the Board of Trustees to serve as a trustee, pursuant to the Bylaws of the Foundation—1979)

Arthur Bernstein, MD ..... South Orange

Utilization Review Task Force, New Jersey Hospital Association Council on Professional Practice
(MSNJ representation requested by New Jersey Hospital Association—January 15, 1992)

Robert J. Weierman, MD ..... South Orange
Joseph C. Lucci ..... Lawrenceville

Waste Management, Advisory Council on Solid
(Appointed by the governor—April 1989)

Stanley R. Lane, MD ..... Moorestown

DOCTORS' NOTEBOOK

TRUSTEES' MINUTES

A regular meeting of the Board of Trustees was held on September 20, 1992, at MSNJ executive offices. Detailed minutes are on file with the secretary of your county society. A summary of significant actions follows:

President's Report. Noted the following: MSNJ is an active participant in the meetings of the Coalition for Health Care Reform; MSNJ, represented by the president, Clark Martin, MSNJ lobbyist, and Neil Weisfeld, MSNJ director of education, research, and regulatory affairs, is trying to develop a legislative agenda to meet the fiscal and health care crisis generated by the federal decision declaring the method of funding uncompensated hospital care in New Jersey illegal under ERISA.

Specialty Societies. Received reports from UMDNJ; the New Jersey Hospital Association; the Academy of Medicine of New Jersey; and the MSNJ Auxiliary.

Executive Director's Report.

1. Litigation. Noted the following: arguments were heard on September 14, 1992, in the case of Stewart versus Sullivan; and MSNJ is continuing to initiate a dialogue with the State Board of Medical Examiners (SBME) concerning the biennial licensing form.

2. Medicare. Noted the following: received a portion of the materials issued by Pennsylvania Blue Shield (PBS) regarding limiting charge violations and PBS stated they will be sending notification of such violations to 1,400 health care providers in New Jersey; MSNJ expects to act in concert with the medical societies of Delaware, Maryland, District of Columbia, and Pennsylvania to oppose the planned splintering of their regional group; and reviewed copies of a proposal for amendment of the medical fee schedule.

Council on Legislation. Approved the following recommendation:

That the Board of Trustees approve the position recommended by the Council on Legislation on *A-1355.*

Also, filed as a resource document, the final draft of the paper on health care reform and uncompensated care prepared by the Subcommittee on Legislative Initiatives of the Council on Legislation, chaired by John Capelli, MD.

Committee on Annual Meeting. Approved the following recommendations:

That the Board of Trustees approve the proposed daily schedule for the 1993 Annual Meeting.

That the 227th Annual Meeting be held at the Trump Taj Mahal Casino/Resort in Atlantic City, New Jersey, on Sunday, May 2, through Wednesday, May 5, 1993.

JEMPAC. Agreed to extend to county medical societies the opportunity to establish county chapters of MedAC and JEMPAC.

Council on Medical Services. Will refer the following recommendations back to the Council on Medical Services for further consideration and rewording:

That the Medical Society of New Jersey declare that physicians should not be compelled to provide free medical care by order of the state, its agencies, or hospitals, in circumstances where others are being paid to provide related or the same services to the needy.

That the Medical Society of New Jersey advise that in the event funds for compensation for medical services are available, the distribution of these funds for inpatient services should be under the control of the medical staff of the appropriate hospital. Distribution of funds for outpatient services should be controlled by a committee under the county society, including physician members who are not necessarily members of the county society.

Council on Medical Services.

1. Subcommittee on Uncompensated Care. Received a report on health care review and the legislative issues on health care reform in uncompensated care.

2. Health Care Reform. Approved as amended by the Board the following recommendations:

That MSNJ endorse the access to health care insurance of a varied nature to every citizen in the state of New Jersey.

That MSNJ categorically oppose a provider tax.

Committee on Education. Approved the following recommendation:

That MSNJ support bill *S-1085* with an amendment to delete the requirement of "one three-credit course each in chemistry, physics, and biology."

Committee on International Medical Graduates. Filed the following recommendation:

That MSNJ support legislation to give the State Board of Medical Examiners greater authority to determine if the applicant's premedical education is satisfactory for licensure.

Committee on Physicians' Health. Approved the following recommendation:

That the Board of Trustees approve the substitute proposal for an alternate resolution program and that it be submitted to the State Board of

Medical Examiners as an official position of MSNJ.

Committee on Long-Range Planning and Development. Defeated the following recommendations:

That the bylaws of MSNJ be amended to permit the election of the speaker and vice-speaker for a fixed term of office.

That a mechanism be established to permit the speaker to be a nonvoting member of the Board of Trustees.

That the bylaws of MSNJ be amended to provide that the speaker, or a committee chaired by the speaker, be charged with the duty to report on an annual basis to the House of Delegates on the results of the actions of the Board of Trustees on the previous year's resolutions.

Also, approved the following recommendations:

That the Board authorize the Committee on Long-Range Planning and Development to proceed with plans for a leadership planning conference, and investigate the options that may be available.

That the Board of Trustees initiate with the Council on Public Relations a full re-evaluation of the strategic plan for public relations.

Meeting with Pennsylvania Blue Shield (PBS). Noted that Mr. Maressa and Mr. Lucci met with representatives of PBS, and full reports on the meeting are available from MSNJ headquarters.

Unfinished Business. Referred to the Council on Medical Services a motion to redefine the definition of the practice of medicine.

New Business. Referred to the Council on Medical Services a motion calling for MSNJ to compile statistics concerning the range of physicians' fees in geographic areas of the state. □

UMDNJ NOTES

Major NIH study on enalapril. Cardiac researchers at UMDNJ-Robert Wood Johnson Medical School, New Brunswick, participated in an international study pointing to a new way to prevent heart failure. Investigators found that giving enalapril to patients with damaged hearts—but no overt symptoms of heart failure—caused dramatic reductions in hospitalizations and a strong trend toward fewer cardiovascular deaths.

The five-year clinical trial, Studies of Left Ventricular Dysfunction (SOLVD), was the first large-scale trial to show that ACE inhibitors such as enalapril can prevent heart failure in patients with severe heart dysfunction.

NJDS receives $600,000 to train dentists. Two grants totalling more than $600,000 will allow UMDNJ-New Jersey Dental School to train ten dentists to treat New Jersey's underserved populations in community health clinics around the state.

The dental school received $493,000 from The Robert Wood Johnson Foundation, Princeton, and $137,000 from the United States Department of Health and Human Services.

Dr. William Cinotti, associate dean for interdisciplinary and extramural programs at the dental school, is principal investigator for the grant and Dr. Richard N. Buchanan, dean of the dental school, is co-investigator.

Sports heroes raise funds. Famous sports figures—including

CANDIDATES FOR MSNJ OFFICES

The MSNJ Nominating Committee will meet on Wednesday, January 20, 1993, to consider candidates. The Committee will consider members other than those recommended by county medical societies and nominating delegates.

If you wish to be considered, please contact your county medical society or the Medical Society of New Jersey, 1/609/896-1766.

This is an opportunity for grassroots candidate development.

MEETINGS OF THE BOARD OF TRUSTEES

of the Medical Society of New Jersey

November 15, 1992

December 20, 1992

January 17, 1993

February 21, 1993

March 21, 1993

Meetings of the Board of Trustees are open to all physicians. For further information, call MSNJ headquarters, 1/609/896-1766.

football's Harry Carson and Ron Johnson, and basketball's Marvin Webster—took the court in the second annual Celebrity Basketball Game to benefit a program for young fathers at UMDNJ-New Jersey Medical School, Newark. The benefit raised $5,000 for the mentorship component of the Young Fathers Program. Mentorship pairs young dads with adult volunteers from business and civic groups, who serve as advisors, friends, and role models. Last year's game also realized approximately $5,000 for the program.

UMDNJ and Newark police raise AIDS funds. A recent basketball game between the UMDNJ All-Stars and the Bronzeshields of the Newark Police Department raised more than $1,600 for University-sponsored programs that assist people living with AIDS.

New laser removes tattoos. A UMDNJ physician is one of a handful in the nation who can remove unwanted tattoos from dark-skinned individuals, such as blacks and Hispanics, by using advanced laser surgery. The new laser therapy also is the first to effectively remove red tattoos from light- and dark-skinned individuals. Dr. Sandy Milgraum, a dermatologic laser specialist at UMDNJ-Robert Wood Johnson Medical School, uses a Q Switched Yag Laser to eradicate the tattoos.

Glaucoma medication. Researchers at UMDNJ-New Jersey Medical School are seeking volunteers to test a new form of medication to treat glaucoma. The study will test a different formulation of the drug pilocarpine, a long-time treatment for glaucoma that helps fluid drain from the eye. Currently, pilocarpine is administered as an eyedrop four times a day. The study will determine whether the drug will last longer in a new solution and be equally effective if administered only twice a day.

Study participants must be at least 18 years old, have no unusual eye problems other than glaucoma, and have had no eye surgery in the past six months. Those who wear contact lenses will not be accepted into the study.

The medical school is one of 12 sites in the country involved in the three-month study. Dr. Cesar Samson, clinical assistant professor of ophthalmology, is principal investigator. ☐ Stanley S. Bergen, Jr, MD, President

AMNJ REPORT

The Association for Hospital Medical Education of New Jersey, the Academy of Medicine of New Jersey (AMNJ), and the Medical Society of New Jersey (MSNJ) hosted a meeting on October 21, 1992, for all physicians and staff involved in continuing medical education (CME) and graduate medical education. This program focused on writing of CME objectives resulting from physicians' needs and how to incorporate this aspect into the program development process.

AMNJ's Head and Neck Oncology Section held a dinner meeting on October 22, 1992. The guest speaker was Louis B. Harrison, MD, chief of brachytherapy service, Department of Radiation Oncology, Memorial Sloan Kettering Cancer Center, New York.

A seminar, "Mental Disorders in the Elderly: Confronting the 21st Century," was held October 23, 1992. The program addressed several areas of the management of mental disorders in the elderly. Renowned authorities discussed features of mental illness in the elderly, defined obstacles to care, and presented new approaches to diagnosis and treatment.

"Clearing the Air: Addressing Nicotine Dependence in the 1990s" cosponsored by AMNJ and MSNJ is scheduled for December 11, 1992, at MSNJ headquarters. This one-day conference provides state-of-the-art information on the management of nicotine dependence, how to deal with one's own smoking, and how to participate in the broader changes necessary to achieve a smoke-free society. To receive a brochure call Pat Walter, 1/609/896-1717.

The Committee on Awards and Special Events of AMNJ still is soliciting recommendations for candidates for the Edward J. Ill and Citizen Awards. The Com-

ARE YOU MOVING?

If so, please send a change of address to *NEW JERSEY MEDICINE*, Medical Society of New Jersey, Two Princess Road, Lawrenceville, NJ 08648, at least six weeks before you move.

Name _____

Old Address _____

City _____ State _____ Zip _____

New Address _____

City _____ State _____ Zip _____

mittee will make its final recommendations for these awards to the Board of Trustees on November 18, 1992, and the announcement will be made immediately afterward. The awards will be presented at the Annual Awards Dinner on May 26, 1993.
☐ George J. Hill, MD, President

PLACEMENT FILE

The following physicians have written to the executive offices of MSNJ seeking information on opportunities for practice in New Jersey. If you are interested in any further information concerning these physicians, we suggest you make inquiries directly to them.

Allergy

Tarun J. Shah, MD, 39C Village of Stoney Run, Maple Shade, NJ 08052. Also, pediatrics. Baroda (India) 1984. Board eligible. Board certified (PED). Solo, partnership, group. Available.

Emergency Medicine

Jayen Shah, MD, P.O. Box 251, Bordentown, NJ 08505. Baroda Medical College 1991. Board certified. Available.

Gastroenterology

Steven Nadler, MD, Robert Wood Johnson University Hospital, MEB 478, GI Division, New Brunswick, NJ 08901. UMDNJ 1987. Board eligible. Board certified (IM). Group, partnership, solo. Available July 1993.

Internal Medicine

Gregory E. Broslawski, DO, 57 Westchester Terr., Annandale, NJ 08801. UMDNJ 1989. Board eligible. Available July 1993.

Nephrology

Vinitha Raghavan, MD, 7 Overbrook Rd., Upper Saddle River, NJ 07458. Guntur Medical College (India) 1981. Board certified (IM). Group or partnership. Available January 1993.

Occupational/Environmental Medicine

Jan Lieben, MD, 2200 Ben Franklin Parkway, #905 South, Philadelphia, PA 19130. Liverpool 1943. Board certified. Part time, 30 hours/week. Available.

Oncology

Barry M. Yafe, MD, 107 Forest St., Providence, RI 02906. New York University 1984. Board certified (ONCOL and IM). Group or partnership. Available.

Surgery

Mark A. Bartolozzi, MD, Westchester County Medical Center, P.O. Box 17, Valhalla, NY 10595. New York Medical College 1987. Board eligible. Partnership. Available.

Jayen C. Shah, MD, P.O. Box 251, Bordentown, NJ 08505. Baroda Medical College 1976. Also, emergency medicine. Board eligible. Hospital based or office. Available.

NEW MEMBERS

The Medical Society of New Jersey would like to welcome the following new members:

Atlantic County

Morris E. Antebi, MD
Nicholas J. Dillman, MD
David A. Dowe, MD
Brett T. Foxman, MD
Andrew S. Glass, MD
Craig S. Glick, MD
Joel E. Krachman, DO
Michael S. Krachman, MD
Eric H. Tiger, MD

Bergen County

Arthur P. Bertolino, MD
Stephen B. Brunnquell, MD
Michele Grodberg, MD
Anthony J. Inguaggiato, MD
Walter A. Klein, MD
George Leib, MD
Steven R. Leibowitz, MD
Bennett P. Leifer, MD
Zinovy Lipsky, MD
Peter A. Luongo, MD
Francis C. Nichols, III, MD
Helena Nouman, MD
Angela M. Palazzo, MD
Aryeh Shander, MD

Camden County

Lance L. Gooberman, MD
Celia Z. Padron, MD
Jonathan H. Weiss, DO

Cape May County

Vinayak M. Sabnis, MD

Cumberland County

Daniel C. Harrer, MD

1993 MSNJ ANNUAL MEETING
May 2, 1993-May 5, 1993
Taj Mahal Casino/Resort
Atlantic City, NJ

Application appears on page 866.

Andrew S. Heller, MD
Seth M. Silver, MD

Essex County

Alan B. Clark, MD
Daneca M. Di Paolo, MD
Prakash J. Doshi, MD
Joseph P. Falcone, MD
Mary Ann Haggerty, MD
John C. Kern, MD
Jed A. Kwartler, MD
Robert M. Rothberg, MD
Sonia P. Tuason-Rufin, MD

Gloucester County

Angelo L. Minutillo, MD

Hudson County

Edward F. Boylan, MD
Jenny G. Cam, MD
Thelma Endaya-Aguila, MD
Juan C. Fischberg, MD
Nicanor C. Go, MD
Paul T. Ittoop, MD
Ana M. Komotar, MD
Danilo C. Mangunay, MD
Nitin A. Parikh, MD
Ram K. Reddy, MD
Edgardo V. Reynoso, MD
Felicisima G. Tolentino, MD

Mercer County

Herman Chmel, MD

Middlesex County

Samya B. Abdul-Shafi, MD
Ara Z. Apelian, MD
Martin D. Fried, MD
Christopher E. Gribbin, MD
Frederic A. Kleinbart, MD
Lynne F. Levy, MD
Rosemary E. McGeady, MD
Cheryl A. O'Brien, MD
Mario F. Pino-Maso, MD
Dinesh K. Singal, MD
Lorna Sohn, MD
Gerald M. Weisfogel, MD

Monmouth County

John S. Clemente, MD
Vincent F. DeStasio, DO
Richard J. Lewis, DO
Anthony J. Micale, MD
Frank J. Scaccia, MD
Mark M. Seckler, MD

Morris County

Arthur S. Campbell, MD
Richard D. Huhn, MD
Theresa H. La Franco, MD
Cynthia K. Menack, MD
Jillian R. Pincus, MD

Ocean County

Shahid Waheed, MD

Passaic County

Jorge H. Amor, MD
Sarva D. Singh, MD

Somerset County

William B. Felegi, DO
Julie Ann Juliano, MD
Gita R. Patel, MD

Union County

Gregory P. Charko, MD
Cheryl A. Krasinski, MD
Marc S. Mandel, MD
Lynne W. Weisberg, MD

DAILY SCHEDULE
1993 MSNJ ANNUAL MEETING

SATURDAY, MAY 1, 1993

3:30 P.M. Board of Trustees Meeting
7:00 P.M. Officers' Reception/Dinner (by invitation only)

SUNDAY, MAY 2, 1993

8:00 A.M. Registration Opens
8:00 A.M. Meeting—AMA Delegation
9:30 A.M. Message Center Opens
10:00 A.M. Educational Program
11:30 A.M. Exhibits Open
12:15 P.M. Academy Lecture
2:00 P.M. House of Delegates
3:30 P.M. Reference Committee Meetings

MONDAY, MAY 3, 1993

7:30 A.M. Breakfast Meeting
8:00 A.M. Registration Opens
8:00 A.M. Message Center Opens
9:00 A.M. House of Delegates (Election)
12:15 P.M. Luncheon "Women in Medicine"
12:30 P.M. Golden Merit Award Ceremony and Reception
2:30 P.M. Reference Committee Meetings
5:00 P.M. JEMPAC Political Forum
5:45 P.M. JEMPAC Wine and Cheese Reception
7:00 P.M. Mercer County Medical Society Reception Honoring William E. Ryan, MD, President

TUESDAY, MAY 4, 1993

8:00 A.M. Registration Opens
8:00 A.M. Message Center Opens
8:30 A.M. Exhibits Open
9:00 A.M. House of Delegates
2:00 P.M. Exhibits Close
6:00 P.M. Inaugural Ceremony
7:00 P.M. Inaugural Reception and Dinner Honoring Joseph N. Micale, MD, Incoming President

WEDNESDAY, MAY 5, 1993

8:00 A.M. Registration Opens
8:00 A.M. Message Center Opens
9:00 A.M. Educational Program
1:00 P.M. Board of Trustees Meeting

HOUSING APPLICATION

227th ANNUAL MEETING
MEDICAL SOCIETY OF NEW JERSEY

May 2 to May 5, 1993

TRUMP TAJ MAHAL CASINO/RESORT
1000 BOARDWALK AT VIRGINIA AVENUE, ATLANTIC CITY, NJ 08401
RESERVATION DEPARTMENT 1/800/825-8786

(Please Print)

Name _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Business Phone _____

Sharing With _____

Date of Arrival _____ Time _____

Date of Departure _____ Time _____

A one-night deposit (equivalent to room rate) is required with all reservation requests. Please send check or money order payable to **TRUMP TAJ MAHAL CASINO/RESORT** or complete the following:

Card # _____ Type _____ Exp. Date _____

SCHEDULE OF RATES SUBJECT TO 12% TAX

☐ SINGLE **$115** ☐ DOUBLE **$115** ☐ Extra Person **$25**

(Reservations must be received prior to April 2, 1993)

☐ One Bedroom Suite **$275 per day**

☐ One Bedroom Hospitality Suite **$300 per day**

Check-out time is 12 NOON. Rooms may not be available for check-in until after 4 P.M. Check-in time on Sundays is 6 P.M. FORTY-EIGHT (48) HOURS NOTICE OF CANCELLATION is required for a full refund. PARKING: FREE PARKING TO REGISTERED GUESTS. One car per room.

☐ Check if Official Delegate County _____

PLEASE NOTE: Effective March 1, 1992, Atlantic City casino hotels must levy a $2 per room, per night hotel room use as legislated by the state of New Jersey.

The proceeds from the fees collected pursuant to this legislation shall be paid into a special fund that will be established and held by the Atlantic City Convention Center Authority. Amounts in the special fund shall be expended by the Convention Center Authority solely for the purposes of promoting tourism, conventions, resorts, and casino gaming.

★★★

Hahnemann University
presents A Medical Seminar

Diagnosis and Treatment of

BREAST CANCER

Wednesday
December 16, 1992
8:30 a.m. to 4 p.m.

Topics include:

- **Screening for breast cancer**
- **Indications for mammography**
- **Diagnostic evaluation of the breast mass**
- **Radiation therapy**
- **Chemotherapy**
- **Breast conservation surgery**
- **Psychosocial support**

For further information, please call 215-762-8263.

Hahnemann
University

Breast Health Center

This program has been developed as a multidisciplinary project by the Departments of Diagnostic Radiology, Medicine, Neoplastic Diseases, Nursing, Radiation Oncology, Social Services, and Surgery, in conjunction with...

Hahnemann University Breast Health Center

GUEST FACULTY

Nancy Davidson, M.D.
Assistant Professor of Oncology, Johns Hopkins Cancer Center, Johns Hopkins School of Medicine, Baltimore, MD

Tish M. Knobf, M.S.N., R.N., F.A.A.N.
Assistant Professor, Yale School of Nursing, Clinical Nurse Specialist, Yale-New Haven Hospital, New Haven, CT

Michael P. Moore, M.D., Ph.D.
Assistant Professor of Surgery, Cornell University School of Medicine, Attending Surgeon, Memorial Sloan-Kettering Cancer Center, New York, NY

PANEL

Recognized experts from the Hahnemann University multidisciplinary team will participate in clinical case presentations and discussions.

Luther Brady, M.D.
Isadore Brodsky, M.D.
Pamela Crilley, D.O.
Nancy Davidson, M.D.
John Harding, M.D.
S. Benham Kahn, M.D.
Bizhan Micaily, M.D.
Michael P. Moore, M.D., Ph.D.
Arthur Patchefsky, M.D.
Jack Sariego, M.D.

INTENDED AUDIENCE:

Oncologists, surgeons, family practitioners, general internists, women's health care specialists, obstetricians, gynecologists, oncology nurses, social workers.

CONFLICT OF INTEREST STATEMENT:

All faculty participating in continuing medical education programs sponsored by Hahnemann University are expected to disclose to the audience any real or apparent conflict(s) of interest related to the content of their presentations.

ACCREDITATION:

AMA - Hahnemann University is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to sponsor continuing medical education for physicians. Hahnemann University designates each hour of attendance at Wednesday's activities for one credit hour of Category 1 of the Physician's Recognition Award of the American Medical Association for a maximum of six credit hours.

Continuing Nursing Education - Contact hours through PNA - pending.

LOCATION:

Classroom C (Alumni Hall) is located on the second floor of the College Building, 15th and Vine Streets. Entrance is off of 15th Street, just south of Vine Street. Discount parking available at the Philadelphia Gateway Garage, 15th and Spring Streets.

CONTINUING EDUCATION

ANESTHESIOLOGY

December

15 **Nonoperative Management of Back Pain**
8:30-9:30 A.M.—United Hospitals Medical Center, Newark
(AMNJ)

19 **Anesthesiologists General Membership Meeting**
All day—Ramada Inn, Clark
(NJ State Society of Anesthesiologists)

DIABETES

December

9 **Diabetes-Related Cardiovascular Disease**
11:30 A.M.-12:30 P.M.—Rahway Hospital, Rahway
(AMNJ and NJDOH)

9 **Diabetic Nephropathy**
1-2 P.M.—VA Medical Center, Lyons
(AMNJ and NJDOH)

January 1993

13 **Diabetes-Related Cardiovascular Disease**
12:30-1:30 P.M.—Kessler Institute for Rehabilitation, West Orange
(AMNJ and NJDOH)

13 **Diabetic Retinopathy**
1-2 P.M.—VA Medical Center, Lyons
(AMNJ and NJDOH)

13 **Diabetic Retinopathy**
8-9 A.M.—Somerset Medical Center, Somerville
(AMNJ)

INFECTIOUS DISEASE

December

2 **Diagnosis and Treatment of AIDS**
11 A.M.-12 NOON—Kessler Memorial Hospital, Hammonton
(AMNJ and NJDOH)

2 **Infection Control in the HIV Era**
1:30-2:30 P.M.—Runnells Specialized Hospital, Berkeley Heights
(AMNJ and NJDOH)

4 **Diagnosis and Treatment of AIDS**
11 A.M.-12:30 P.M.—Hamilton Hospital, Trenton
(AMNJ and NJDOH)

4 **Identification and Management of Asymptomatic HIV Infection**
10-11 A.M.—Marlboro Psychiatric Hospital
(NJDOH and AMNJ)

9 **Integrating TB Management into Care of the HIV-Infected Patient**
12:30-1:30 P.M.—Kessler Institute for Rehabilitation, West Orange
(NJDOH and AMNJ)

9 **Diagnosis and Treatment of AIDS**
8-9 A.M.—Somerset Medical Center, Somerville
(AMNJ and NJDOH)

16 **Integrating TB Management into Care of the HIV-Infected Patient**
10-11 A.M.—The Hospital Center at Orange, Orange
(NJDOH and AMNJ)

16 **Identification and Management of Asymptomatic HIV Infection**
6-7 P.M.—Rancocas Hospital, Willingboro
(NJDOH and AMNJ)

18 **Integrating TB Management into Care of the HIV-Infected Patient**
12 NOON-1 P.M.—South Jersey Hospital System, Bridgeton
(AMNJ and NJDOH)

January 1993

5 **Chronic Epstein-Barr Virus**
12 NOON-1 P.M.—The Hospital Center at Orange, Orange
(AMNJ and NJDOH)

6 **Identification and Management of Asymptomatic HIV Infection**
9-10 A.M.—Elizabeth General Medical Center, Elizabeth
(NJDOH and AMNJ)

7 **Diagnosis and Treatment of AIDS**
10-11 A.M.—Hunterdon Developmental Center, Clinton
(AMNJ and NJDOH)

11 **Identification and Management of Asymptomatic HIV Infection**
1-2 P.M.—New Lisbon Developmental Center
(NJDOH and AMNJ)

11 **Integrating TB Management into Care of the HIV-Infected Patient**
3-4 P.M.—MCOSS Nursing Services, Red Bank
(AMNJ and NJDOH)

13 **Identification and Management of Asymptomatic HIV Infection**
8-9 A.M.—Children's Specialized Hospital, Mountainside
(NJDOH and AMNJ)

13 **Identification and Management of Asymptomatic HIV Infection**
11 A.M.-12 NOON—Kessler Memorial Hospital, Hammonton
(NJDOH and AMNJ)

13 **Integrating TB Management into Care of the HIV-Infected Patient**
11 A.M.-12 NOON—West Hudson Hospital, Kearny
(AMNJ and NJDOH)

18 **Identification and Management of the HIV-Indeterminant Infant**
12 NOON-1 P.M.—Community Medical Center, Toms River
(AMNJ and NJDOH)

PHILADELPHIA HEART INSTITUTE

at Presbyterian Medical Center

Cardiology Update

designed for the physician and provides an intensive survey of the current status of clinical cardiology . . .

Wednesday, December 2, 1992

Premature Ventricular Beats: Benign vs. Life-Threatening Arrhythmias

Moderator: Francis E. Marchlinski, M.D.

3:00-3:30	The role of signal-averaging and holter monitoring; the interpretation of the PVC: In what company it keeps!—***Mark Preminger, M.D.***
3:30-4:00	Drugs vs. AICD vs. surgery for life-threatening ventricular arrhythmias—***Francis E. Marchlinski, M.D.***
4:00-5:00	Case Presentations—***Roman Pachulski, M.D.*** Panel Discussion—***Charles D. Gottlieb, M.D., Joel Morganroth, M.D., Mark Preminger, M.D., Mark Rosenthal, M.D.***

- *Case Presentations and Panel Discussions*
- *CME Credits**
- *No Registration Fee*
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**Presbyterian Medical Center designates this continued medical education activity for 2 credit hours in Category I of the Physicians' Recognition Award of the American Medical Association and the Pennsylvania Medical Society Membership requirement. Nine sessions, 18 credits.*

19 **Infection Control in the HIV Era**
1:30-2:30 P.M.—Kimball

MEDICINE

December

1 **Acute Renal Failure**
12 NOON-1 P.M.—The Hospital Center at Orange, Orange
(AMNJ)

1 **Romantic Love in Therapy and Marriage**
8:30-10 A.M.—Elizabeth General Medical Center, Elizabeth
(Elizabeth General Medical Center)

2 **Pediatric Society Meeting**
8:30 A.M.-4 P.M.—Sheraton Hotel, Woodbridge
(AMNJ and NJ Pediatric Society)

2 **Medical Problems in the Elderly**
8-9 A.M.—Somerset Medical Center, Somerville
(AMNJ and NJDOH)

2 **Child Sexual Abuse and Neglect**
9-10 A.M.—Riverview Medical Center, Red Bank
(AMNJ)

2 **Endocrinology Grand Rounds**
11:30 A.M.-1 P.M.—VA Medical Center, East Orange
(AMNJ)

2 **National Health Care Reform**
8-10 P.M.—Voorhees Middle School, Voorhees
(The PRO of NJ, Inc.)

2 **Interhospital Endocrine Rounds**
3:30-5 P.M.—Rotating hospitals in Newark and East Orange
(AMNJ)

3 **Current Concepts in Medicine and Surgery**
10 11:45 A.M.—JFK Medical
17 Center, Edison
(JFK Medical Center)

4 **Geriatrics: Camouflaged Medical Illness**
10:30-11:30 A.M.—Marlboro Psychiatric Hospital, Marlboro
(AMNJ)

4 **Grand Rounds**
18 9-10 A.M.—St. Francis Medical Center, Trenton
(St. Francis Medical Center)

6 **Endocrinology Grand Rounds**
11:30 A.M.-12:45 P.M.—VA Medical Center, East Orange
(AMNJ)

6 **Endocrinology Case Conference**
4-5 P.M.—University Hospital, Newark
(AMNJ)

6 **Endocrinology Dinner Meeting**
6 P.M.—Holiday Inn, Newark Airport, Newark
(AMNJ)

7 **Endocrinology Grand Rounds**
9:30-10:30 A.M.—Newark Beth Israel Medical Center, Newark
(AMNJ)

8 **Role of Culture in Mental Illness**
8:30-10 A.M.—Elizabeth General Medical Center, Elizabeth
(Elizabeth General Medical Center)

9 **Competitive Initiatives Program**
12:15-1:30 P.M.—John Fitch Plaza, Trenton
(AMNJ and NJDOH)

9 **Endocrinology Grand Rounds**
11:30 A.M.-1 P.M.—VA Medical Center, East Orange
(AMNJ)

9 **Interhospital Endocrine Rounds**
3:30-5 P.M.—Rotating hospitals in Newark and East Orange
(AMNJ)

10 **Obsessive-Compulsive Disorder**
5-6 P.M.—Somerset Medical Center, Somerville
(Somerset Medical Center)

10 **Failure of U.S. To Provide Socialized Medicine**
6-7:30 P.M.—Robert Wood Johnson University Hospital, New Brunswick
(UMDNJ)

11 **Addressing Nicotine Dependence in the 1990s**
8:30 A.M.-4:30 P.M.—MSNJ headquarters, Lawrenceville
(AMNJ and MSNJ)

14 **Aspirations Syndrome in the Mentally Retarded**
1-2 P.M.—New Lisbon Developmental Center, New Lisbon
(AMNJ)

15 **Treatment of Anxiety in Alcoholism**
8:30-10 A.M.—Elizabeth General Medical Center, Elizabeth
(Elizabeth General Medical Center)

16 **Medical Problems in the Elderly**
11:30 A.M.-12:30 P.M.—Rahway Hospital, Rahway
(AMNJ and NJDOH)

26 **AIDS Treatment**
Medical Center, Lakewood
(AMNJ and NJDOH)

12 NOON-1 P.M.—West Jersey Hospital, Voorhees
(AMNJ and NJDOH)

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If so, please send a change of address to *NEW JERSEY MEDICINE*, Medical Society of New Jersey, Two Princess Road, Lawrenceville, NJ 08648, at least six weeks before you move.

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City _____ State _____ Zip _____

Hahnemann University

Department of Medicine Grand Rounds
Wednesdays 8:30 a.m.-9:30 a.m.

NOVEMBER 1992

November 4, 1992
HYPOTHYROIDISM: PATHOGENESIS AND IMMUNE MECHANISMS
E. Chester Ridgway, III, M.D.
Professor of Medicine
Head, Division of Endocrinology
University of Colorado Health Science Center
Denver, CO

November 11, 1992
LV REMODELING: CELLULAR AND THERAPEUTIC CONSIDERATIONS
Gary S. Francis, M.D.
Professor of Medicine
Cardiovascular Division
University of Minnesota School of Medicine
Minneapolis, MN

November 18, 1992
IMMUNOLOGIC INTERVENTIONS FOR RHEUMATOID ARTHRITIS: FROM FALLACIOUS TO EMPIRIC TO TARGETED APPROACHES
David E. Trenthan, M.D.
Associate Professor of Medicine
Harvard Medical School
Chief, Division of Rheumatology
Beth Israel Hospital
Boston, MA

November 25, 1992
Thanksgiving Holiday—No Grand Rounds

DECEMBER 1992

December 2, 1992
ASTHMA BY INGESTION: ASPIRIN, SULFITE, M.S.G. AND TARTRAZINE SENSITIVITY
Ronald Simon, M.D.
Associate Clinical Professor of Medicine & Pediatrics
University of California/San Diego School of Medicine
Head, Division of Allergy & Clinical Immunology
Scripps Clinic and Research Foundation
La Jolla, CA

December 9, 1992
CHOLESTEROL REDUCTION IN PRIMARY PREVENTION: UNANSWERED QUESTIONS AND UNQUESTIONED ANSWERS
Jeremy Swan, M.D., Ph.D.
Professor of Medicine
UCLA School of Medicine
Los Angeles, CA

December 16, 1992
BIOLOGICAL FACTORS OF BREAST CANCER: EARLY DIAGNOSTIC AND PROGNOSTIC INDICATORS
Nancy Davidson, M.D.
Assistant Professor of Oncology
Johns Hopkins Cancer Center
Johns Hopkins School of Medicine
Baltimore, MD

EARLY STAGE BREAST CANCER: PATIENT SELECTION CONTROVERSIES
Michael P. Moore, M.D., Ph.D.
Assistant Professor of Surgery
Cornell University School of Medicine
Attending Surgeon
Memorial Sloan-Kettering Cancer Center
New York, NY

December 23, 1992
Christmas Holidays—No Grand Rounds

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Hahnemann University Department of Medicine Wednesday Medical Seminar Series 8:30 a.m.—3:30 p.m.

November 18, 1992
MECHANISMS AND STRATEGIES FOR TREATING AUTOIMMUNE DISEASES
Course Director: Richard L. Spielvogel, M.D.
Guest Faculty: Alice Gottlieb, M.D.
Richard P. MacDermott, M.D.
David E. Trenthan, M.D.

December 2, 1992
ASTHMA
Course Directors: David M. Lang, M.D.
Guest Faculty: Ronald Simon, M.D.

December 16, 1992
BREAST CANCER: DIAGNOSIS AND TREATMENT
Course Codirectors: Jeffrey Brodsky, M.D.
Pamela Crilley, D.O.
Guest Faculty: Michael P. Moore, M.D., Ph.D.
Nancy Davidson, M.D.

Seminar Director:

Allan B. Schwartz, M.D.
Professor and Vice Chairman of Medicine
Director, Continuing Medical Education for the Department of Medicine

Location:

Classroom C (Alumni Hall)
2nd Floor New College Building
Hahnemann University
15th Street Entrance
15th & Vine Streets
Philadelphia, PA

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As an organization accredited by the Accreditation Council for Continuing Medical Education (ACCME), Hahnemann University designates this continuing medical education activity as Category 1 of the Physician's Recognition Award of the American Medical Association. One credit hour may be claimed for each hour of participation by the individual physician.

16 **Endocrinology Grand Rounds**
11:30 A.M.-1 P.M.—VA Medical Center, East Orange
(AMNJ)

16 **Interhospital Endocrine Rounds**
3:30-5 P.M.—Rotating hospitals in Newark and East Orange
(AMNJ)

16 **Journal Club**
2:30-4 P.M.—Greystone Park Psychiatric Hospital, Greystone Park
(Greystone Park Psychiatric Hospital)

17 **Critical Care—ICU Priorities**
12 NOON-1 P.M.—Helene Fuld Medical Center, Trenton
(Helene Fuld Medical Center)

18 **Parkinsonism**
10:30-11:30 A.M.—Marlboro Psychiatric Hospital, Marlboro
(AMNJ)

23 **Endocrinology Grand Rounds**
11:30 A.M.-1 P.M.—VA Medical Center, East Orange
(AMNJ)

23 **Interhospital Endocrine Rounds**
3:30-5 P.M.—Rotating hospitals in Newark and East Orange
(AMNJ)

30 **Endocrinology Grand Rounds**
11:30 A.M.-1 P.M.—VA Medical Center, East Orange
(AMNJ)

30 **Interhospital Endocrine Rounds**
3:30-5 P.M.—Rotating hospitals in Newark and East Orange
(AMNJ)

January 1993

5 **Chronic Epstein-Barr Virus**
12 NOON-1 P.M.—The Hospital Center at Orange, Orange
(AMNJ)

6 **Endocrinology Meeting**
6 P.M.—Holiday Inn, Newark Airport
(AMNJ)

6 **Endocrinology Grand Rounds**
11:30 A.M.-12:45 P.M.—VA Medical Center, East Orange
(AMNJ)

6 **Endocrinology Conference**
4-5 P.M.—University Hospital, Newark
(AMNJ)

7 **Occupational Asthma in New Jersey**
8-9 A.M.—Somerset Medical Center, Somerville
(AMNJ)

7 **Medical Grand Rounds**
9:30-10:30 A.M.—Newark Beth Israel Medical Center, Newark
(AMNJ)

8 **Smoking Cessation**
10:30-11:30 A.M.—Marlboro Psychiatric Hospital, Marlboro
(AMNJ)

11 **Medical Problems in the Elderly**
11:30 A.M.-12:30 P.M.—Columbus Hospital, Newark
(AMNJ)

13 **Diabetic Retinopathy**
8-9 A.M.—Somerset Medical Center, Somerville
(AMNJ)

13 **Endocrinology Grand Rounds**
11:30 A.M.-1 P.M.—VA Medical Center, East Orange
(AMNJ)

13 **Interhospital Endocrine Rounds**
3:30-5 P.M.—Rotating hospitals in Newark and East Orange
(AMNJ)

15 **Nonoperative Management of Back Pain**
8:30-9:30 A.M.—United Hospitals Medical Center, Newark
(AMNJ)

15-16 **American College of Physicians Meeting**
Sheraton Woodbridge Hotel, Woodbridge
(AMNJ)

15-17 **Winter Ski Weekend**
Great Gorge
(NJ Academy of Family Physicians)

19 **Insights into Protein Wasting in Uremia**
6 P.M.—Overlook Hospital, Summit
(Nephrology Society of NJ)

20 **Endocrinology Grand Rounds**
11:30 A.M.-1 P.M.—VA Medical Center, East Orange
(AMNJ)

20 **Interhospital Endocrine Rounds**
3:30-5 P.M.—Rotating hospitals in Newark and East Orange
(AMNJ)

20 **Robert Wood Johnson Medical School Dermatological Conference**
6-9 P.M.—Rutgers Community Health Plan, 57 U.S. Highway 1, South, New Brunswick
(UMDNJ, Division of Dermatology)

21 **Update on Risks of Smoking**
5-6 P.M.—Somerset Medical Center, Somerville
(Somerset Medical Center)

22 **Applied Psychotherapy for Office Practice**
10:30-11:30 A.M.—Marlboro Psychiatric Hospital
(AMNJ)

26 **Medical Problems in the Elderly**
2-3 P.M.—New Jersey Veterans Home, Paramus
(AMNJ and NJDOH)

27 **Medical Problems in the Elderly**
12 NOON-1 P.M.—Southern Ocean County Hospital, Manahawkin
(AMNJ)

27 **Endocrinology Grand Rounds**
11:30 A.M.-1 P.M.—VA Medical Center, East Orange
(AMNJ)

27 **Scientific Meeting**
6:30-9:30 P.M.—The Manor, West Orange
(Radiation Oncology Section, AMNJ)

27 **Interhospital Endocrine Rounds**
3:30-5 P.M.—Rotating hospitals in Newark and East Orange
(AMNJ)

28 **Keeping Love Alive**
6:30-7:30 P.M.—UMDNJ-Robert Wood Johnson University Hospital, New Brunswick
(AMNJ)

PEDIATRICS

December

2 **Annual Meeting**
8:30 A.M.-4:30 P.M.—Sheraton Hotel, Woodbridge
(NJ Pediatric Society)

PSYCHIATRY

December

2 **Psychiatric Case Conference**
1:30-2:30 P.M.—Greystone Park Psychiatric Hospital, Greystone Park
(AMNJ)

9 **Post-traumatic Stress Disorders**
1:30-2:30 P.M.—Greystone Park Psychiatric Hospital, Greystone Park
(AMNJ)

10 **Obsessive-Compulsive Disorder**
5-6 P.M.—Somerset Medical Center, Somerville
(Somerset Medical Center)

16 **Journal Club**
2:30-4 P.M.—Greystone Park Psychiatric Hospital, Greystone Park
(AMNJ)

22 **Cognitive Unconsciousness**
8:30-10 A.M.—Elizabeth General Medical Center, Elizabeth
(Elizabeth General Medical Center)

RADIOLOGY

December

15 **Scientific Meeting**
7:30-10 P.M.—Saint Barnabas Medical Center, Livingston
(Radiological Society of NJ and Diagnostic Radiology Section)

17 **Meeting, MRI Conference, and Case Presentation**
7:30 P.M.—Saint Barnabas Medical Center, Livingston
(Radiological Society of NJ)

24 **Visiting Lecture Series**
1:30-5:30 P.M.—Saint Barnabas Medical Center, Livingston
(Saint Barnabas Medical Center)

January

21 **Scientific Meeting**
7:30-10 P.M.—Saint Barnabas Medical Center, Livingston
(Radiological Society of NJ and Diagnostic Radiology Section)

28 **Visiting Professor Lecture**
1:30-5 P.M.—Saint Barnabas Medical Center, Livingston
(Department of Radiology)

MSNJ WRITING COMPETITION
INTERNS/RESIDENTS/FELLOWS/STUDENTS

A **$500 AWARD** will be presented by the Medical Society of New Jersey to the intern, resident, fellow, or 4th-year medical student who submits the best paper on a clinical subject for the Society's 1992 Competition.

Entries should be "sponsored" by a faculty member, and all papers submitted should be of sufficient quality to be considered for publication in *NEW JERSEY MEDICINE*.

Entrants need not be members of the Medical Society of New Jersey, but must be in training at a New Jersey hospital, studying at an institution in the state of New Jersey, or be a resident of New Jersey.

Entries must be submitted by December 1, 1992. The winning paper will be published in a future issue of *NEW JERSEY MEDICINE*. Other noteworthy manuscripts will be considered for publication by the Editorial Board of *NEW JERSEY MEDICINE*.

Send two copies of the manuscript to:

Howard D. Slobodien, MD
NEW JERSEY MEDICINE
Two Princess Road, Lawrenceville, NJ 08648

All papers and photographs will be returned. If you have any questions, please call the offices of *NEW JERSEY MEDICINE* at 1/609/896-1766.

IN MEMORIAM

EDMUND R. CYTOWIC

We have received word of the death of Edmund Richard Cytowic, MD, on June 21, 1992. He was born in Schenectady, New York, on July 25, 1922. Dr. Cytowic attended Hahnemann Medical College, Philadelphia, graduating in 1947. The following year, Dr. Cytowic received his New Jersey medical license. Dr. Cytowic was a family physician; he practiced and resided in Trenton and Florida. Dr. Cytowic was on staff at the former William McKinley Memorial Hospital, Trenton. He was a member of our Mercer County component, of the Academy of Medicine of New Jersey, and of the American Medical Association; he was a fellow of the American Geriatric Society and of the American Academy of Family Practice. Dr. Cytowic was a United States Navy veteran.

NORMAN N. FORNEY, JR

Retired since 1981, Norman Nes Forney, Jr, MD, passed away on June 20, 1992. Dr. Forney was born in Milltown on September 9, 1910. He was a 1937 graduate of Temple University School of Medicine, Philadelphia. Dr. Forney was a general surgeon on staff at Middlesex General Hospital and St. Peter's Medical Center, both in New Brunswick. Dr. Forney practiced in Milltown. He was a member of our Middlesex County component and of the American Medical Association, and a fellow of the American College of Surgeons. He resided in Milltown and retired to North Carolina.

HUBERT G. HUMPHREY

Born in 1910 in Westfield, Hubert Grant Humphrey, MD, died on June 16, 1992. Dr. Humphrey was awarded a medical degree from Howard University College of Medicine, Washington, DC, in 1935. After completing an internship at Freedmen's Hospital, Washington, DC, Dr. Humphrey received his New Jersey medical license in 1936. Dr. Humphrey was a general practitioner with offices in Bloomfield and Westfield. He was affiliated with Muhlenberg Regional Medical Center, Plainfield. Dr. Humphrey was a member of our Union County component, of the American Medical Association, of the National Medical Association, and of the Scotch Plains Board of Health; he was president of the Westfield Medical Society in the late 1950s. Dr. Humphrey resided in Scotch Plains.

SEYMOUR P. JASLOW

West Orange resident Seymour Paul Jaslow, MD, died on April 3, 1992; he was born in New York City on December 5, 1909. Dr. Jaslow was awarded a medical degree from New York University School of Medicine, New York, in 1936. After completing an internship at the Hospital for Joint Diseases, New York, in 1938, Dr. Jaslow practiced in New York City until 1943. Later Dr. Jaslow, an internist, practiced in Wyckoff for over 30 years. During his medical career, Dr. Jaslow was president of the medical staff at Barnert Memorial Medical Center, Paterson; and medical director of Daughters of Miriam Center for the Aged, Clinton, and of Theresa Grotta Rehabilitation Center, West Orange. Dr. Jaslow

was an assistant professor at the University of Medicine and Dentistry of New Jersey, Newark. He was a member of our Passaic County component and of the American Medical Association, and a fellow of the American Academy of Family Practice and of the American Geriatric Society.

JOHN J. KOBES

We regret to announce the death of John Jacob Kobes, MD, on June 13, 1992. Dr. Kobes was born on September 24, 1903, in the Netherlands. He graduated from the University of Cincinnati College of Medicine, Ohio, in 1932. Dr. Kobes was a general surgeon and was on staff at West Hudson Hospital, Kearny. He was a member of our Essex County component and of the American Medical Association. Dr. Kobes was a World War II veteran. He resided in Arlington and Sea Girt.

CHARLES KUTNER

We have been notified of the death of Charles Kutner, MD, at the grand age of 91, on April 9, 1992. Dr. Kutner was born on December 7, 1900, in Camden. He was awarded a medical degree from the University of Maryland School of Medicine, Baltimore, in 1927. An allergy specialist, Dr. Kutner maintained a practice in Camden and was affiliated with Cooper Hospital, Camden. Dr. Kutner was a member of our Camden County component and of the American Medical Association. Dr. Kutner was a World War II veteran.

LAWRENCE J. MACATEE

A 1961 graduate of Temple University School of Medicine, Lawrence Joseph Macatee, MD, died on May 17, 1992. Dr. Macatee was born in Havertown, Pennsylvania, in 1936. He completed an internship at Misericordia Hospital, Philadelphia, in 1962. Dr. Macatee's military service in the United States Navy from 1962 to 1965 was followed by a residency at Methodist Hospital, Philadelphia. He received licenses to practice in New Jersey and in Pennsylvania in 1975 and 1965, respectively. During Dr. Macatee's career as a gynecologist-obstetrician, he maintained a practice in Philadelphia and in Cape May Court House; was attending at Methodist Hospital and at St. Agnes Hospital, both in Philadelphia and at Burdette Tomlin Memorial Hospital, Cape May Court House; and was a clinical instructor at Jefferson Medical College, Philadelphia. Dr. Macatee was a member of our Cape May County component, of the Philadelphia County Medical Society, and of the American Medical Association; a diplomate of the American Board of Obstetrics and Gynecology; and a fellow of the American College of Obstetricians and Gynecologists.

HARRY B. MCCLUSKEY

At the grand age of 83, Harry Brendan McCluskey, MD, passed away on June 11, 1992. He was born in Orange on January 19, 1909. Dr. McCluskey earned a medical degree from Jefferson Medical College, Philadelphia, in 1935. He completed an internship at Williamsport Hospital, Pennsylvania, and a residency at Essex County Isolation Hospital and at the New Jersey State Hospital, Greystone Park. In 1936, Dr. McCluskey received his New Jersey medical license. Dr. McCluskey was an internist and practiced in Short Hills, East Orange, Whippany, and Pompano Beach, Florida. Dr. McCluskey was affiliated with

Saint Michael's Medical Center, Newark; Orange Memorial Hospital; Cypress Community Hospital, Pompano Beach, Florida; and Imperial Point Hospital, Holy Cross Hospital, and North Ridge Hospital, all in Fort Lauderdale, Florida. Dr. McCluskey was a member of our Essex County component and of the American Medical Association; a diplomate of the American Board of Internal Medicine; and a fellow of the American College of Physicians and of the American College of Gastroenterology. Dr. McCluskey was a World War II United States Army veteran.

SAMUEL R. MILLER

A lifelong resident of Pennington, Samuel Robert Miller, MD, passed away on July 19, 1992. Dr. Miller was born in Trenton on November 6, 1908. He attended Hahnemann Medical College, Philadelphia, earning a medical degree in 1933. The following year, Dr. Miller received his license to practice medicine in New Jersey. He completed an internship at Helene Fuld Medical Center, Trenton. A general practitioner, Dr. Miller spent his medical career practicing in Pennington. He was on staff at Helene Fuld Medical Center. Dr. Miller was a member of our Mercer County component and of the American Medical Association. Dr. Miller was a World War II United States Army Air Corps veteran.

CARL A. NACCA

Carl Anthony Nacca, MD, died on May 3, 1992. He was born on August 10, 1906, in West Orange. Dr. Nacca was a 1932 graduate of Georgetown University School of Medicine, Washington, DC. He received his license to practice medicine in New Jersey in 1933. Dr. Nacca completed an internship at St. Mary's Hospital, Orange. He was a general practitioner and was affiliated with St. Mary's Hospital, Orange; Orange Memorial Hospital; and Columbus Hospital, Newark. Dr. Nacca was a member of our Essex County component and of the American Medical Association.

GORDON V. STODDARD

We regret to announce the death of Gordon Vail Stoddard, MD, on May 7, 1992. Dr. Stoddard was born on February 18, 1904, in Madison. He was a 1930 graduate of Hahnemann Medical College, Philadelphia. After completing an internship at The Mountainside Hospital, Montclair, and a residency at East Orange General Hospital, Dr. Stoddard received his New Jersey medical license in 1932. During his career as a cardiologist, Dr. Stoddard practiced in East Orange. He was on staff at East Orange General Hospital and was a member of our Essex County component, of the American Medical Association, of the American Heart Association, and of the Academy of Medicine of New Jersey. Dr. Stoddard served in the U.S. Air Force during World War II.

JOHN ZAPPALA

Family practitioner John Zappala, MD, died on June 1, 1992. He was 88 years old. After being awarded a medical degree from Hahnemann Medical School, Philadelphia, in 1931, Dr. Zappala completed an internship at St. Mary's Hospital, Philadelphia. Dr. Zappala practiced in Penns Grove and Swedesboro. He was affiliated with Salem Memorial Hospital. Dr. Zappala was a member of our Salem County component and of the American Medical Association.

STATEMENT OF OWNERSHIP, MANAGEMENT, AND CIRCULATION

(Required by 39 U.S.C. 3685)

1A. Title of Publication: *NEW JERSEY MEDICINE, The Journal of the Medical Society of New Jersey.*

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	Extent and nature of circulation	Average no. copies each issue during preceding 12 months	Actual no. copies of single issue published nearest to filing date
A.	Total no. copies (net press run)	10,577	10,466
B.	Paid and/or requested circulation		
	1. Sales through dealers and carriers, street vendors, and counter sales	—	—
	2. Mail subscription (paid and/or requested)	9,975	9,955
C.	Total paid and/or requested circulation (sum of 10B1 and 10B2)	9,975	9,955
D.	Free distribution by mail, carrier, or other means: samples, complimentary, and other free copies	402	311
E.	Total distribution (sum of C and D)	10,377	10,266
F.	Copies not distributed		
	1. Office use, left-over, unaccounted, spoiled after printing	200	200
	2. Return from news agents	—	—
G.	Total (sum of E, F1, and 2—should equal net press run shown in A)	10,577	10,466

11. I certify that the statements made by me above are correct and complete.

(signed) Geraldine R. Hutner
Managing Editor

EDITORIAL CRITERIA

CONTENT

NEW JERSEY MEDICINE is the official organ of the Medical Society of New Jersey. The goals are educational and informational. All material published is copyrighted by the Medical Society of New Jersey.

The educational contents of each issue appear as scientific articles, based on research, original concepts relative to epidemiology of disease, and treatment methodology; case reports; review articles; clinical notes; state of the art reports; and special articles, that include evaluations, policy and position papers, and reviews of nonscientific subjects. Other topics include professional liability commentary; critical narration; medical history; pediatric briefs; nutrition update; and opinions. Editorials are prepared by the editor and by guest contributors on timely and relevant subjects. The Doctors' Notebook section contains organizational and administrative items from the Medical Society of New Jersey and from the community. Letters to the editor and book reviews are welcome and will be published as space permits.

The principal aim in the preparation of a contribution should be relevance to diagnosis and treatment and to the education of patients and professionals. Preference will be given to authors from New Jersey and to out-of-state lecturers submitting a suitable manuscript based on a presentation made to an audience in New Jersey.

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SPECIFICATIONS

Submit two manuscripts that must be typewritten and double spaced on 8½″ by 11″ paper. Statistical methods used in articles should be identified.

The title page should include the full name, degrees, and affiliations of all authors, and the name and address of the author to whom reprint requests and correspondence should be sent.

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Tables must be typewritten and double spaced on separate 8½″ by 11″ sheets, with a title and number. Symbols for units should be confined to column headings, and abbreviations should be kept to a minimum.

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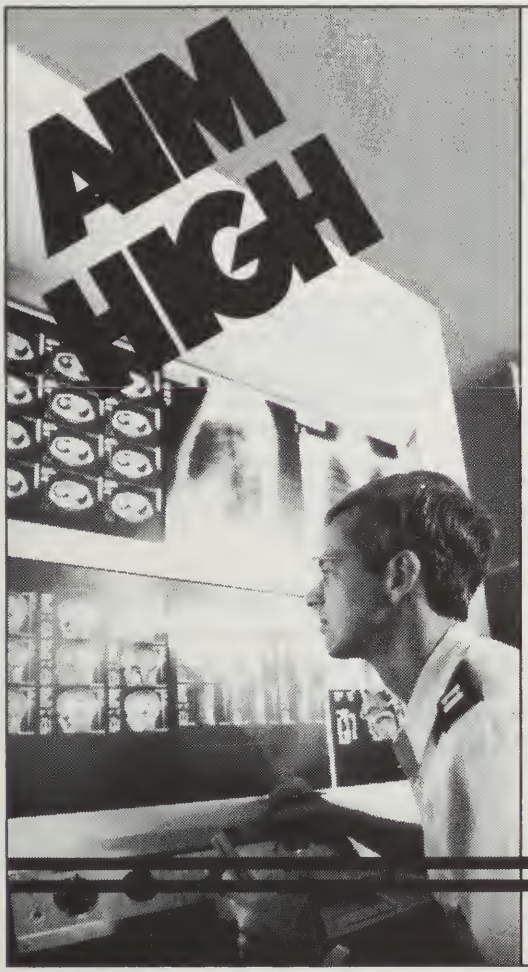
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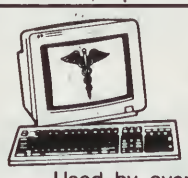
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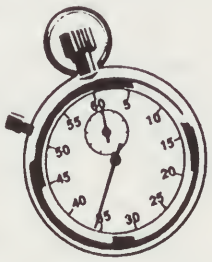
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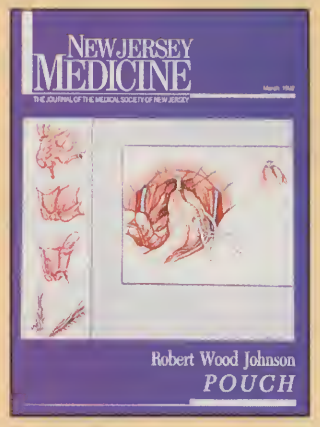
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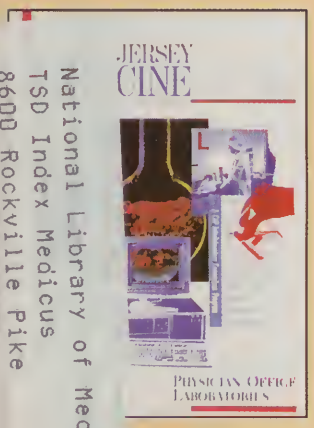
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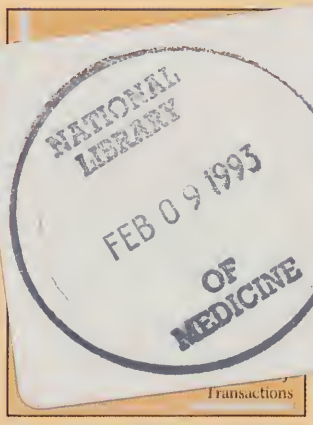




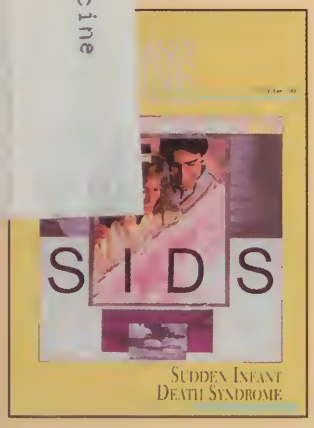


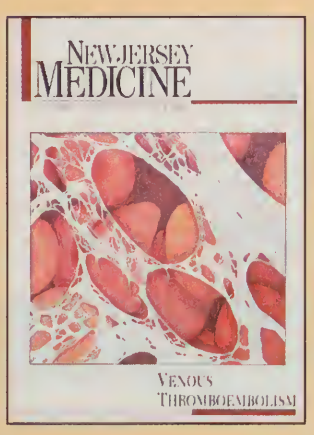


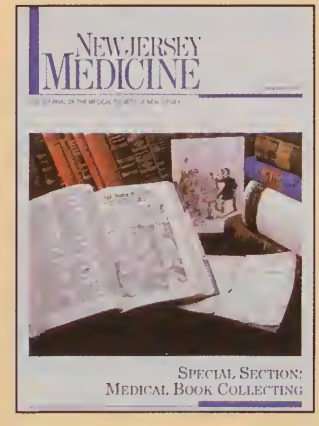














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TUBERCULOSIS IN HOSPITALS...

Thirteen percent of reporting hospitals, in a survey with a 59 percent response rate, have informed the Centers for Disease Control and the American Hospital Association that tuberculosis (TB) has been transmitted to health care workers in their facility. In an additional finding, described as "somewhat shocking," clerical workers at the 88 hospitals where transmission occurred had as high a rate of infection as patient care nurses.

To combat TB, and especially the new multiple drug-resistant strains associated with AIDS, hospitals with outbreaks have

been advised to test personnel every three to four months. Hospitals further are advised to employ environmental controls, including negative pressure isolation rooms, respiratory protection, and proper ventilation systems.

In federal region 2--New Jersey, New York, Puerto Rico, and the Virgin Islands--Occupational Safety and Health Administration officials are considering requiring health care workers to wear costly and cumbersome respiratory protection devices in the presence of patients with TB. The dust, mist, and fume respirators, with battery packs, apparently impede breathing and communication with patients.

December 1992

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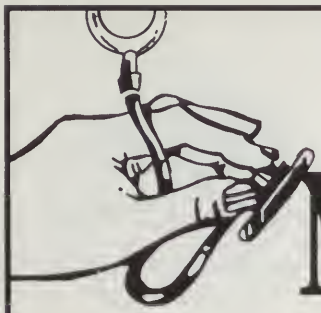
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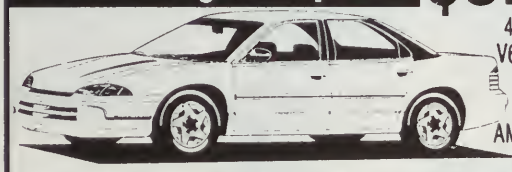


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1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical Letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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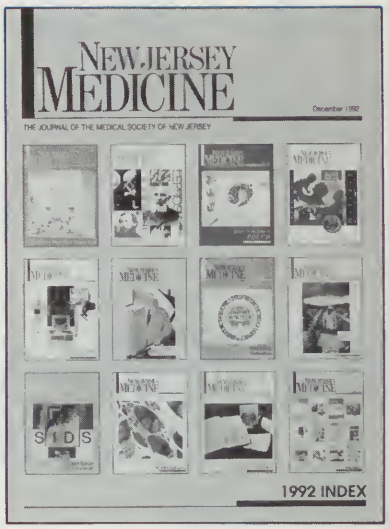
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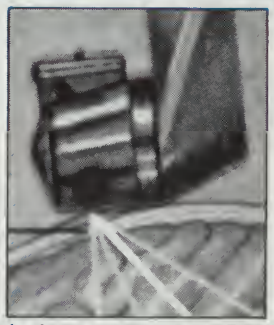
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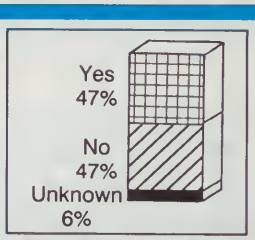
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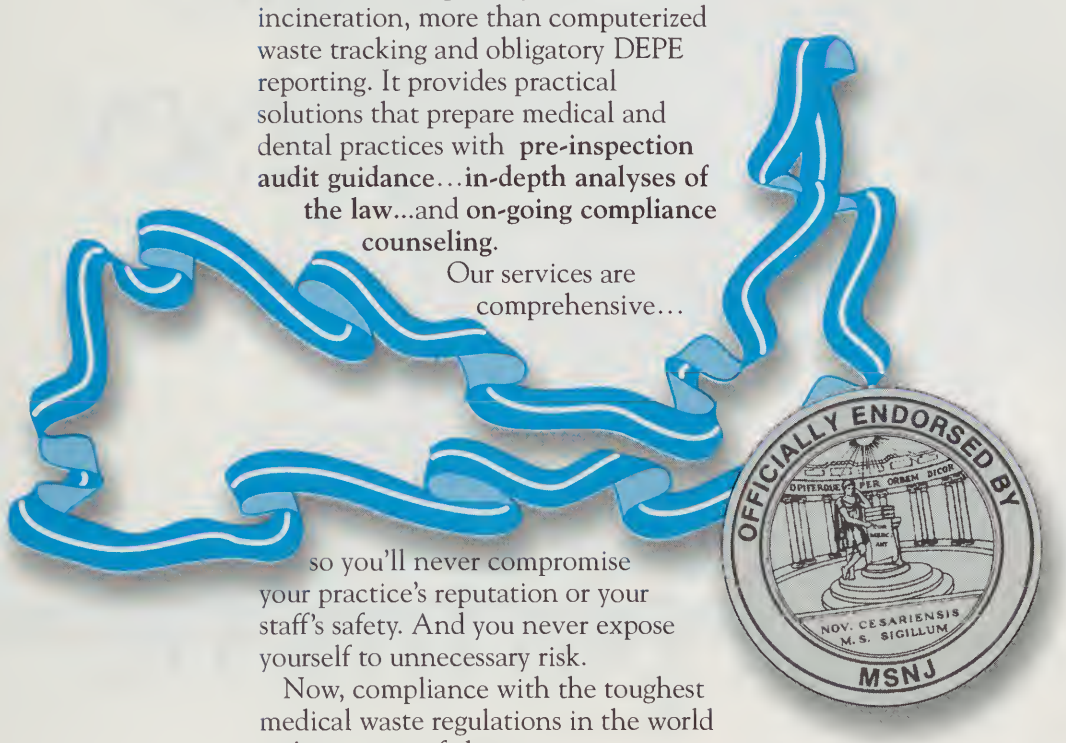
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MSNJ NEWSLETTER

RECEPTION FOR DR. DUNSTON

Retiring State Health Commissioner Frances J. Dunston, MD, MPH, was honored at a reception at the Masonic Temple in Trenton. The Medical Society of New Jersey (MSNJ) and the New Jersey Hospital Association (NJHA) collaborated in awarding a plaque to Dr. Dunston and providing flowers for the reception. Shown as the plaque is being presented are NJHA vice-president Ron Czajkowski; Dr. Dunston, and MSNJ president William E. Ryan, MD.



PHYSICIANS NEEDED

The New Jersey Division of Disability Determinations is in need of physicians in private or group practice to perform consultative examinations. The Division adjudicates claims for Social Security Administration. For more information, contact: Richard Cohen, Division of Disability Determinations, P.O. Box 649, Newark, NJ 07101.

MSNJ REACTS TO NJ SHIELD PROPOSAL

William E. Ryan, MD, president of the Medical Society of New Jersey, reacted within hours to Governor Florio's proposal on October 28, 1992, to launch a new subsidized insurance program to replace the state's beleaguered uncompensated care trust fund. Dr. Ryan generally supported the proposal, dubbed NJ SHIELD, for New Jersey State Health Insurance Enrollment and Local Health Delivery.

In a news statement Dr. Ryan stated: "We agree with the governor that it is essential to get people out of hospital emergency rooms who do not belong—and thus are draining our health care dollars—and instead steer them to treatment by primary care physicians." The president added, "We support the concept of a sliding income scale with modest copayments as a means of getting consumers to take more

responsibility for their own health."

Under the new plan, there no longer would be a trust fund to reimburse hospitals, and only hospitals, for care given to uninsured patients. Instead, patients who cannot afford insurance but are ineligible for Medicaid would receive state assistance in purchasing health insurance with a managed care component.

The NJ SHIELD proposal is similar to portions of a comprehensive package of actions recommended by the New Jersey Health Care Reform Coalition, which includes MSNJ, the state Business and Industry Association, labor organizations, the New Jersey Hospital Association, the Health Insurance Association of America, and numerous other private sector organizations. The Coalition recommendations emphasize competition among health care providers and payers, as opposed to state regulation.

BIOMEDICAL ETHICS

The Citizens' Committee on Biomedical Ethics, the Hastings Centers, Rutgers University, and the University of Medicine and Dentistry will be holding an intensive Bioethics Conference on April 23 to 26, 1993, at the Sheraton Tara Hotel in Parsippany. Participants will be helped to understand better the nature and language of ethics as they address topics such as the distribution of resources, the development of end-of-life guidelines, the role of surrogate decision makers, and the impact of advance directives. Led by an outstanding faculty, participants will attend lectures, small group workshops, and mock ethics committee sessions. The conference fee is $375. For further information, call 1/908/277-3858.

PHYSICIAN HONORS

Hackensack Medical Center honored the 512 doctors on its staff with its annual Physicians Recognition Evening, held at the Glenpointe Hotel in Teaneck. Special awards were presented to those physicians who have given over 25 years of service, as well as those physicians who retired within the past year as department directors or from the medical staff. Among the recipients was Selma Mitchel, MD, a member of the Medical Society of New Jersey and senior attending physician in the Department of Pediatrics at Hackensack Medical Center, with her husband, Stanley, who was recognized for 35 years of service. □



Selma and Stanley Mitchel

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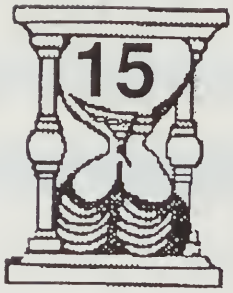
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PROFESSIONAL LIABILITY

HEALTH CARE FINANCING

Medicare suit dismissed. On October 26, 1992, a federal district court judge dismissed a claim brought against Medicare by a New Jersey physician and several of her patients. The plaintiffs had sought court permission for elderly patients to contract with a physician for medical care under direct payment, outside of the Medicare system.

Dismissal of the suit was based on the court's determination that physicians are in no immediate danger of sanctions for engaging in such an arrangement with patients. The lack of sanctions reflects the court's opinion that there is no real issue for litigation.

The plaintiffs had claimed that physicians face sanctions for privately contracting with Medicare-eligible patients at fees that exceed Medicare reimbursement levels. But, counsel for the federal government said the government would not oppose such agreements, provided that the patient signs a waiver that includes the acknowledgement that the covered services might be considered excessive under Medicare. Moreover, said the government, any sanctions would have to be based on repeated violations of regulations.

Fee limits upheld. Another defeat for physicians who treat Medicare patients occurred in the U.S. Court of Appeals for the Second Circuit, which includes New Jersey. The case, brought by the Medical Society of the State of New York, addressed the issue of whether a state could set physician fees at a level below those allowed by Medicare. Yes, indeed, said the court.

A New York state law that took effect in January 1991 prohibits physicians from charging Medicare beneficiaries more than 115 percent of Medicare allowable charges in 1991 and 1992, or an even smaller amount in subsequent years. (The smaller amount is 105 percent of the allowable charge if the number of Medicare claims filed in the state does not increase by at least 5 percent from the previous year's level, or else 110 percent.)

By contrast, the Federal Omnibus Budget Reconciliation Act of 1989 permits physicians to "balance bill" for 125 percent of the allowable charge in 1991, 120 percent in 1992, and 115 percent in subsequent years. The physician group contended that Congress had "pre-empted" Medicare reimbursement, so that states could not enact legislation interfering with the congressional scheme. But, the court found no clear manifest congressional intent to pre-empt this area.

Action at the state level. Even though President-elect Clinton and Democratic congressional leaders seek to enact national health reform early in 1993, states are likely to continue to serve as laboratories for diverse health reform initiatives. As The Robert Wood Johnson Foundation President Stephen Schroeder, MD, had noted in remarks to the 1992 National Health Policy Forum in Washington, DC, states can demonstrate how to move the country forward in health policy.

Dr. Schroeder observed that states are eager to participate in policy development, but that many state efforts are blocked at the federal level, due to such constraints as difficulty in obtaining Medicaid waivers and requirements of the Employee Retirement Income Security Act. State reform is a compelling issue in New Jersey, where alternative proposals have been advanced by the New Jersey Health Care Reform Coalition (that includes the Medical Society of New Jersey), by Governor Florio through his NJ SHIELD (New Jersey State Health Insurance Enrollment and Local Health Delivery) proposal, and by Republican leaders of the Legislature.

Medicare cap proposed. Two influential middle-of-the-road senators from opposite political parties, Sam Nunn (D-Georgia) and Pete Domenici (R-New Mexico) have joined forces to recommend spending caps in Medicare, Medicaid, and other federal entitlement programs other than Social Security. Under the proposal of the two senators' Strengthening of America Commission, spending under the programs could rise by no more than the rate of inflation plus growth in the beneficiary population.

Without such limits, the giant federal health programs are projected to increase between 11 and 13 percent annually for the next ten years. But, the proposal fails to account for the increasing proportion of very old people, who present the greatest health care demand, within the Medicare population.

More physicians excluded for joint venture. Coming down against physicians even more harshly than an administrative law judge, the United States Department of Health and Human Services' (DHHS) Appeals Board has ruled that physicians should be excluded from the Medicare program for two years for participating in a joint venture in violation of the anti-kickback law, even if the physicians had not been proved untrustworthy. When a physician is found to have violated the law, said the

Board, the burden is on the physician to prove trustworthiness, and the uncertain state of the law has no bearing on the question of whether a physician can be trusted to obey the law in the future.

MALPRACTICE VERDICTS

Undiagnosed hemorrhagic pancreatitis. A 45-year-old man, whose prior history included a finding of elevated triglyceride levels, presented to a family physician with abdominal pain accompanied by vomiting after ingesting a meatball sandwich. Upon establishing differential diagnoses of food poisoning and gastroenteritis, the physician administered an injection of Tigan® and provided an antispasmatic for the stomach. Two days later, the patient telephoned the physician and received prescriptions for more of the antispasmatic and Tigan® suppositories. Four days after the call, the patient's wife found him in a semi-responsive state, and he was taken to the hospital where he died as a result of hemorrhagic pancreatitis.

In dispute in a subsequent malpractice trial in New Jersey were the extent of the patient's initial pain—the plaintiff claimed that the pain radiated to the back, which the physician, pointing to his records, denied—and the patient's description of his condition that he gave to the physician by telephone two days after the office visit. The physician testified that the patient then reported significant improvement, but the plaintiff noted that the physician nonetheless ordered prescriptions, and the patient's widow testified that he had been consuming large quantities of fluids during the interim. The patient's secretary also testified as to the patient's weakened condition on the day of the call.

An endocrinologist testified for the plaintiff that elevated triglycerides frequently are associated with pancreatitis, and that the defendant should have considered this association from the start. When symptoms did not abate for two days, a blood test to confirm the diagnosis clearly was indicated, added the expert. With a proper diagnosis, the patient would have been hospitalized on a timely basis and been supplied with nutrients intravenously, said the expert, so that the condition could resolve. In an application of a recent state Supreme Court ruling, the endocrinologist was allowed to refer to a learned treatise in support of his contentions. To buttress the expert's testimony further, the plaintiff claimed that another physician had confirmed the triglyceride finding several months previously and, at that time, advised the family physician to investigate.

The defendant's view was that a virus causing gastroenteritis was responsible for the patient's condition at the time of the visit, and that this condition developed into pancreatitis later. By the time the pancreatitis would have been diagnosed, asserted the defense, it was already hemorrhagic and carried a 50 percent risk of fatality. However, the medical examiner who performed the autopsy asserted that the hemorrhagic stage was reached only about 24 hours before death, so that earlier successful intervention would have been possible.

The decedent was an attorney and volunteer firefighter, who left a widow and two adult children. The jury found for the plaintiff and awarded $841,000.

Testicular torsion. Testicular swelling and a history of testicular pain led an unmarried 20-year-old youth to seek care in a hospital emergency department. An emergency physician diagnosed epididymitis, prescribed a broad-based antibiotic, and advised against sexual activity. When the pain and swelling increased during the next two and one-half days, the patient visited another hospital, where testicular torsion was diagnosed. The testicle was surgically removed, and the patient sued the original physician in a New Jersey court for malpractice.

Testifying for the plaintiff, a urologist stated that the physician should have considered testicular torsion immediately and ordered a urologic consult due to the need to intervene quickly to prevent testicular loss. The urologist further contended that the defendant should have followed through to determine whether urinalysis revealed the presence of infection, which would have supported the defendant's diagnosis.

In defense, the physician said that he did not remember the patient but that he probably ruled out testicular torsion based on the information available. Another emergency physician and urologist testified on his behalf that testicular torsion seldom occurs after age 18, and that the plaintiff's prior history included epididymitis, which recurs in half the patients who contract it.

The expert urologists disagreed about the effects of the failure to establish the correct diagnosis earlier. The plaintiff's expert said that the ensuing increase in pain and swelling demonstrated that arterial flow was continuing and that the testicle could have been saved. The defense witness said that the testicle remains viable for more than six hours in only 5 percent of testicular torsion cases. But, the defense witness found himself unable to express an opinion as to the plaintiff's case, so that the plaintiff's attorney argued that the defense had failed to establish a percentage probability of losing the testicle.

The plaintiff also testified as to his shame resulting from the loss. He said that he had not told his friends of the surgery. The court instructed the jury to ignore the plaintiff's suggestion that the loss

of a testicle is analogous to a mastectomy. The parties agreed that he could continue to engage in sexual relations. Despite the divided evidence and the relatively limited loss, the jury found for the plaintiff and awarded $250,000. The award was not reduced through an apportioning of the chances of losing the testicle, as the jury further found that the defense had not proved that it could establish a probability of loss.

Cervical pregnancy. Pregnant at age 35, a patient with two children visited an obstetrician-gynecologist three times to complain of progressively heightening abdominal bleeding and severe pelvic pain. Eventually the pain progressed to the point where an emergency hysterectomy was performed, based on a diagnosis of an ectopic pregnancy within the cervix—a condition that occurs in 1 of 18,000 pregnancies. Bleeding at the time of the procedure was so severe that 16 pints of blood were administered and a painful uterine clamp was applied, compelling the patient to lie with her legs forced apart for more than three days following surgery.

In a malpractice action brought in New Jersey, the patient claimed that the physician negligently failed to make the diagnosis in a timely manner, thereby failing to prevent the extensive bleeding that caused the postoperative recovery to be more painful and degrading than it otherwise would have been. An expert obstetrician-gynecologist testified for the plaintiff that the cervical pregnancy was clearly observable on ultrasound, and an expert radiologist added on the plaintiff's behalf that the defendant should have made the proper diagnosis. Also, the plaintiff vividly recalled her post-surgical discomfort, including leg spasms for several months in addition to the immediate pain and embarrassment.

The defendant noted according to his records, the plaintiff complained of minor spotting, not extensive heightening bleeding. He and his own expert obstetrician-gynecologist denied that the cervical pregnancy was observable through ultrasound. The plaintiff's counsel observed that the defense expert uses the plaintiff's radiologic expert in his professional practice. The jury awarded $150,000 for the plaintiff and $5,000 to her husband.

MALPRACTICE POLICY DEVELOPMENTS

Federal report attacks system. "Medical liability demonstrates no dependable or equitable causal connection with medical negligence," agreed participants in a working conference on malpractice convened by the United States DHHS. In an undated report of 1991 discussions, the federally assembled experts also called for creation of a schedule of standard awards geared to severity of injury with a straight factor for setting economic damages.

The experts concluded that nonmeritorious claims are not effectively rejected through the legal process, and that lay juries cannot be relied on to determine complicated medical and other scientific facts in a dependable fashion. Moreover, transaction costs for the legal system are excessive, and awards frequently are incommensurate with severity of injury, according to the report. Additionally, the report observed that plaintiffs in medical malpractice cases typically win greater compensation than people who are injured in other ways.

Liability fact sheets available. Kits containing "medical liability fact sheets" are being disseminated by the American Medical Association/Specialty Society Medical Liability Project. The kits may be especially helpful in preparing presentations to lay audiences.

National Practitioner Data Bank. Issues of a threshold, abuse, and confusion in the use of the National Practitioner Data Bank have been addressed in diverse forums. First, the Health Resources and Services Administration in the DHHS has completed a study of whether a minimum dollar threshold should be established for mandatory reporting of malpractice payments to the Data Bank. *Medical Liability Monitor*, a weekly newsletter, suggests that the federal officials will recommend against a threshold, so that all payments, no matter how small, still will have to be reported.

Second, the American Medical Association (AMA) and other concerned groups are cautioning against use of the Data Bank by health maintenance organizations (HMOs) and other third-party payers. In some instances physicians who seek to participate in managed care programs are required to obtain a report on themselves from the Data Bank and then forward the report to the HMO. The California Medical Association (CMA) has advised physicians who face such demands to ask for written documentation of the requirement coupled with written assurance that the confidentiality of the report will be protected. Do not give reports to anyone not prohibited by law from disclosing the contents, says CMA.

Third, DHHS has released *Guidebook Supplement* on use of the Data Bank. The *Guidebook* resolves some, but not all, of the confusion about which events must be reported. Summary suspensions of privileges must be reported, it says, if the suspension is for more than 30 days, is based on conduct or competence that could adversely affect a patient, or resulted from professional review. Withdrawals of applications for privileges must be reported if the withdrawal was made to stop an investigation or review. Settle-

ment agreements in which the physician is released from further liability are reportable—but not dismissals from suits that occur before a settlement or judgment is made.

Commentators had advised the *Health Law Reporter*, a publication of the Bureau of National Affairs, Inc., that DHHS recognizes the problems caused by long delays in obtaining reports from the Data Bank. To avoid being dependent on the Data Bank's slow pace, DHHS advises hospitals to make credentialing decisions on the basis of factors other than the Data Bank reports and not to wait for reports. (Interesting advice, in view of the presumed purpose of these reports.) Liability insurers reporting small malpractice claims are urged to supplement their reports with brief descriptive information about the merit of the claim. According to the Government Accounting Office, 44 percent of all claims reported during the Data Bank's initial year were under $30,000.

LICENSURE

New medical board rules. By February 18, 1993, any New Jersey physician with a "significant beneficial interest" (any financial arrangement or ownership interest) in another health care service must so notify the State Board of Medical Examiners.

Several other actions are required under the Board's new business practice rules, as reported previously in *NEW JERSEY MEDICINE*.

- Post a notice conspicuously in the office waiting room saying, "INFORMATION ON PROFESSIONAL FEES IS AVAILABLE TO YOU UPON REQUEST."
- If you held a significant beneficial interest in another health care service before July 31, 1991—or if you hold an interest in a radiation therapy, lithotripsy, or renal dialysis service—disclose that interest, when you refer patients to the service, through a written form that also is posted conspicuously in your office.
- Refrain from referring patients to other health care services in which you hold an interest (except for services provided in your office and billed under your name).
- Do not give or accept any materially valuable gift that "a reasonable person would recognize as having been given or received in appreciation for, or to promote, referrals."

One of the few liberalizing features of the new rules is permission for physicians to band with other health professionals in multispecialty practices, under various conditions. A summary of the rules has been issued as a special bulletin by the health law department of the Cooper Perskie law firm in Northfield and Voorhees.

MALPRACTICE TIPS

Informing patients about fees. Sixty-three percent of respondents in a Gallup poll conducted for the AMA said their doctors do not discuss fees with them. (This figure may rank in seriousness as a warning sign with an earlier reported finding from another study that physicians interrupt patients on average 18 seconds into the patient's initial statement of the presenting complaint.) A similar 63 percent said they did not feel that physicians involved them sufficiently in decisions, and fewer than one-third said that doctors' fees are reasonable.

To combat the poor patient relations—and malpractice exposure—that result from noncommunication about fees, the AMA currently supports voluntary posting in office waiting rooms of fees for frequently performed procedures. *Loss Minimizer*, a monthly newsletter, also suggests the following measures for physicians uncomfortable with fee discussions:

- Prepare and distribute a patient information brochure explaining billing practices.
- Distribute a fee schedule to patients on request.
- Encourage consulting specialists to prepare fact sheets, and advise patients on referral that the specialist will bill separately.
- Reduce unnecessary testing by obtaining the patient's authorization to obtain previous medical records, and sharing test results with other physicians.
- In large practices, retain a patient accounts manager, who orients each new patient to the business aspects of the practice and is available in the office or by telephone.
- Attach a note indicating what will happen next when you mail patients a copy of bills sent to insurers. ☐ James E. George, MD, JD; and Neil E. Weisfeld, JD, MSHyg

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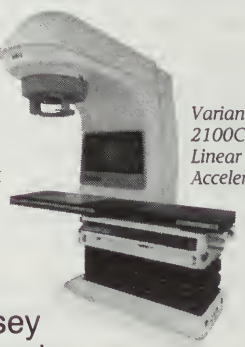
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BOOK REVIEWS

LIVING ALLERGY FREE

M. Eric Gershwin, MD, and Edwin L. Klingelhofer, PhD. Totowa, NJ, Humana Press, 1992. In this book, *Living Allergy Free: How To Create and Maintain an Allergen- and Irritant-Free Environment,* the authors review the field of allergy with a specific bent toward educating patients to develop an allergy-free environment. However, other topics discussed include responses of the skin and respiratory tract to pollen and irritants. A major success of the book is the clear separation of allergic and non-allergic/irritant reactions and the attempt to eradicate patients' misconceptions regarding fad diets and vitamins from more scientific approaches. This book examines all aspects of allergy and irritant exposures with effective chapters that focus on food allergy versus intolerance, as well as skin sensitivity.

Pitfalls of the book include its slightly disjointed flow of chapter structure and its lack of specificity in the field of allergy. The book also directs attention to occupational disease, dedicating a section to worker's compensation and a chapter discussing sick building syndrome.

In spite of the aforementioned problems, this book should be complemented for a fairly thorough discussion of the many facets of allergic disease. Allergists may be surprised by the lack of attention devoted to the discussion of in vitro versus in vivo/immediate skin testing.

Finally, this book should only be recommended to an erudite patient population, as the language is quite technical, but extremely well written. □ John J. Oppenheimer, MD, and Leonard Bielory, MD

LONG-TERM TREATMENT OF DEPRESSION

S.A. Montgomery and F. Rouillon (eds). New York, NY, John Wiley and Sons, 1992. As a current reference source for several different aspects of the epidemiology, diagnosis, differential diagnosis, comorbidity (with other psychiatric and medical disorders), and treatment of depression and other affective disorders, *Long-Term Treatment of Depression* is highly recommended. It is the third in a series of contemporary volumes entitled "Perspectives in Psychiatry." It consists of wide-ranging chapters by international authors, with an apparent intended audience of psychiatrists and psychopharmacologists. Despite its multiple authors, the chapters present a coherent and cohesive biologically oriented overview of the topic, emphasizing the need to view depressive disorders as long-term, chronic, and recurrent, and to orient treatment—especially psychopharmacologic treatment.

Long-Term Treatment of Depression is technical, detailed, and comprehensive in its chapter reviews of such topics as recurrence in depressive disorders, duration of treatment, chemoprophylaxis of depressive and other affective disorders, unwanted effects of long-term treatment, lithium and bipolar illness, and psychological treatment in the prevention of relapse. The presentation of this volume is detailed and scholarly, with little commentary or information of practical value offered to the practicing physician or psychiatrist—the readership of *NEW JERSEY MEDICINE*—with several notable exceptions. The excep-

tions include side effects of pharmacotherapy ("Unwanted Effects of Long-Term Treatment"), management of compliance ("Lithium and Bipolar Illness"), advisability of concomitant pharmacologic and psychological long-term treatment of depression ("Psychological Treatments in Prevention of Relapse"), and potential clinical hazards of long-term treatment with benzodiazepines ("Comorbidity of Mood Disorders and Anxiety States"). This volume is heavily oriented toward biological psychiatry and psychopharmacology, with only one chapter dealing specifically with psychological treatment ("Psychological Treatments in Prevention of Relapse"). Despite this strong pharmacologic orientation, however, there is very little discussion of the role of substance abuse/chemical dependency in the long-term treatment of depression; this is a shortcoming of the volume.

In summary, *Long-Term Treatment of Depression* is a current, scholarly, and detailed monograph intended for psychiatric and psychological researchers and academicians. Although generally comprehensive in its scope, a major omission of this volume is its lack of discussion concerning substance abuse in the context of long-term treatment of depression. This volume is highly recommended to its intended audience and to medical libraries as a valuable reference source, but not to the practicing psychiatrist, physician, or other mental health professional. ☐ Daniel P. Greenfield, MD, MPH, MS

MRI IN PEDIATRIC NEURORADIOLOGY

Samuel M. Wolpert and Patrick D. Barnes. St. Louis, MO, Mosby-Year Book, 1992. As magnetic resonance imaging (MRI) has become the imaging modality of choice in the evaluation of pediatric neurological diseases, the level of interaction between radiologists and clinical specialists has risen accordingly. In recognition of this fact, Drs. Wolpert and Barnes have produced a text geared toward both sets of physicians, a text that bridges the communication gap that can delay decision making.

"Basic Principles of Pediatric Neuroradiology" heads the first part of this volume. The chapter on the physics of MRI summarizes the biophysical basis of image contrast. The following discussion, "The Clinical Principles of Pediatric Neuroradiology," affords an excellent description of the role of each of the various imaging modalities (ultrasound, computed tomography [CT], and MRI) in the determination of adult as well as pediatric neurological diseases. Moreover, the authors suggest imaging approaches for the more common clinical problems, e.g. headache, seizure, developmental delay.

The second part of the book centers on brain imaging. All aspects are covered, including an extensive chapter on neoplastic diseases. Each chapter provides a synthesis of plain films, angiography, CT, and MRI. The scans consistently rate a state-of-the-art ranking. The last part of the book is devoted to spinal diseases. Clinical manifestations, pathological correlation, and neuroimaging are artfully blended to form a comprehensive review. Small charts that highlight each section accompany the highly organized discussions. The result is an easy-to-read, valuable reference for the field. ☐ Neil B. Horner, MD

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LETTERS AND VIEWPOINTS

ONCOLOGY RESEARCH

The article by Dennis Devereux, MD, entitled, "Treatment of Hepatic Metastases from Colorectal Origin (*NJ MED* 89:521-524, 1992) is provocative and clearly addresses an important issue in oncology, namely the role of hepatic resection as a possible curative maneuver in a subgroup of cancer patients for whom the inevitable alternative is death from progressive malignancy.

Nevertheless, many of the author's comments are speculative and raise certain troubling questions that make interpretation of the paper problematic.

In the first place, the text alludes to the author's experience of 15 cases, but nowhere is this experience tabulated or substantiated (Table 1 provides unrelated information). Has this material been previously published? How may the reader assess the validity of the data?

Second, the entire object of the paper is to describe a proposed clinical research project. The title of the article is misleading, since it suggests that this approach may already be an established methodology, which it is not. The purpose of publishing this material is not clear; could this merely be a solicitation for subjects to be enrolled in the study?

The questions posed near the end of the article seem overly ambitious and not likely to be answered satisfactorily by the proposed study. This is described as a phase II study (to define the appropriateness of a purported new treatment) but the questions raised seem more properly targeted to a phase III type of situation (comparative data analysis).

Finally, certain presumptions by the author relating to predictions of behavior of micrometastatic disease, based on an observed effect upon macroscopic tumors, are highly controversial and may result in erroneous conclusions.

It is my contention that publication of cancer research material in this form does not suitably inform the readership regarding advancements in the science of medicine. It is encouraging that capable oncology researchers in New Jersey are dealing seriously with relevant clinical problems of this kind. I look forward to perusing the results of completed and suitably peer-reviewed work in the future. ☐ Alan J. Lippman, MD

ONCOLOGY RESEARCH

We agree with Dr. Lippman's assessment that the management of metastatic colorectal carcinoma is an important issue in oncology. The role established by hepatic resection is well accepted in the surgical literature as a possible curative maneuver in certain subsets of patients. The establishment of the effective role of 5-fluorouracil and levamisole in colon cancer and 5-fluorouracil and leucovorin in the treatment of metastatic colorectal carcinoma also is established in certain subsets of patients.

One of our concerns, as those specializing in the treatment of oncologic patients, is the observation that there seems to be a casual acceptance that metastatic colon carcinoma is a death sentence. We designed this phase II study to determine if the combination of chemotherapy plus surgery resulted in a better outcome than historical controls treated by either method alone. If we can determine the effectiveness of the combination of these treatment modalities, then a phase III study (the comparison of surgery versus chemotherapy–versus surgery plus chemotherapy) will be undertaken. We had hoped that this article will be provocative in the sense that a statewide attempt at answering the question may one day be undertaken. We do agree with Dr. Lippman that this entity requires further investigation and are looking forward to meeting that challenge in the future. ☐ Dennis F. Devereux, MD and Michael J. Nissenblatt, MD

EDITOR'S DESK

HAVE A HEART

H.G. Wells used the term "atomic bomb" in 1914. We had found in 1939 that uranium 235 could be split and yield more energy than that needed to produce the split. And finally, 50 years ago on December 2, 1942, the first self-sustaining chain reaction took place in a uranium oxide "pile" at the University of Chicago, ushering in the atomic age.

Most of the ensuing years saw a mad race of the superpowers to obtain nuclear superiority and of the would-be powers to obtain nuclear respectability by developing the capability to bomb with the big boys. Even today, after the world has escaped largely unscathed from the Cuban missile crisis and other tensions of the Cold War, worries persist that some crazy individual still can precipitate atomic destruction.

As many politicians and their military chieftains escalated testing and proliferation of weapons, efforts were made to utilize nuclear power as a source of energy. (Coincidentally, December 18, 1992, marks the 35th anniversary of the establishment of the first commercial nuclear power plant in the United States at Shippingport, Pennsylvania.) But the debate, punctuated by debacles at Three Mile Island, Chernobyl, and other locations, continues to rage and searches have intensified for alternate sources.

As the use of radiation energy for military purposes has dissipated and its promulgation as a source of energy has faltered, medical applications have proliferated and prospered. Diagnostic radiology is alive and well, having expanded throughout the years. Techniques and equipment have undergone extensive refinement



Howard D. Slobodien, MD

and state-of-the-art radiography now is safer and infinitely more diagnostic than could have been dreamed of in 1942. Radionuclides have expanded even further the diagnostic and therapeutic capabilities, often with lesser radiation exposure than with alternate methods. Organs and systems, previously hidden and difficult to evaluate, have yielded many of their secrets. Thyroid, liver and spleen, biliary systems, intestines, bones, blood vessels, lungs, and heart now are accessible via radioisotopes—and this is a partial listing. The future for further advances is bright, limited only by the imagination of chemists, physicists, and others who will develop new and innovative products.

Radioactive isotopes also have been used therapeutically for neoplasms and other conditions of the thyroid, head and neck, breast, and other locations. But radiation therapy is administered more commonly by external sources, usually supervoltage in type. Both early and late complications, of varying severity, can occur. Whole body radiation will produce drastic effects on the immune response; even localized radiation can alter this response. And that leads us to a second anniversary of note.

On December 3, 1967, Dr. Christiaan Barnard, aided by 30 associates in a five-hour operation, made medical history at Groote Schuur Hospital in Capetown, South Africa, when Louis Washkansky, a 55-year-old grocer who had suffered a progressively failing heart, received the heart of a 25-year-old motor vehicle accident victim, Denise Ann Davall. Dr. Barnard said, "My moment of truth—the moment when the enormity of it all really hit me—was just after I had taken out Washkansky's heart. I looked down and saw this empty space." The patient died of pneumonia 18 days postoperatively, the new heart beating almost to the end. One month later, Dr. Barnard performed his second cardiac transplant. The patient, Philip Blaiberg, lived 19 months.

Many surgeons jumped onto the bandwagon, most lacking the knowledge and skills of Dr. Barnard and unwilling to be also-rans or non-starters. But the problems of cardiac transplantation, especially that of rejection, were much more complex than those of the well-established kidney transplantation. By early 1969, over 100 operations had been done in 18 different countries, most patients dying from hours to a few months after their operations. Some semblance of sanity and prudence returned as the toll rose. Two years later only nine cardiac transplants were performed. Since the early failures, newer methods and

materials have ameliorated the difficulties with technique and rejection and cardiac transplantation today shows dramatic successes; more than 60 percent of patients now survive at least five years.

We presently have successful transplantation in anatomic sites considered unthinkable or impossible a generation ago. The boundaries may be well circumscribed by political and economic considerations and not by the imagination of members of the transplantation teams, even though many economists calculate positive financial benefits of some transplants when added years of productive life are factored into the cost equations. (The reader is advised to watch for a special issue on transplantation in *NEW JERSEY MEDICINE* in spring 1993.)

It is challenging to attempt to find a common theme in the apparently unrelated events of 1942 and 1967. But the immune response is a common thread linking nuclear energy to transplantation. Immunosuppression, even temporarily, is a negative aspect of radiation used for therapeutic or diagnostic purposes. On the other hand, it almost is a sine qua non for transplant success and much of the progress in the field is owed to improved suppressive techniques. We have said it before—one man's meat is another's. . . . As an aside, one of life's great ironies today also relates to the immune system. Immunosuppression keeps the organ transplant viable, but it shortens the lives of many others, including some of our most talented, imaginative, and creative individuals—those afflicted with today's plague, AIDS.

We now are in the middle of the holiday season that extends from Thanksgiving to New Year's Day. Most of us can give thanks for many blessings, including the one of good health. Even more of us can enter into the traditional holiday spirit of giving, sometimes of money, certainly of self—ranging from the mind's acceptance of those who are different to the physical act of organ donation.

Once again, many thanks are due to the staff of MSNJ and *NEW JERSEY MEDICINE,* to the Committee on Publication, the Editorial Board, and its reviewers, and to you, the reader.

Happy holidays and a healthy 1993 to all. □ Howard D. Slobodien, MD

Paradoxes are useful to attract attention to ideas.

Mandell Creighton,
Life and Letters, 1904

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Emerson, "Gifts"
Essays, Second Series, 1844

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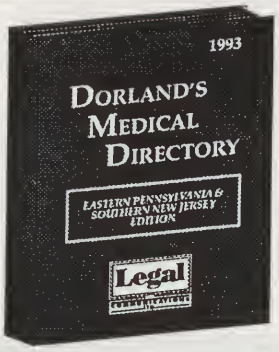
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PRESIDENT 'S PAGE

HEALTH CARE REFORM IN NEW JERSEY

The time to replace the uncompensated care funding mechanism is at hand. The New Jersey Health Care Reform Coalition has written a series of recommendations, including funding, which has become public. In October 1992, the governor detailed a proposal to deal with this issue, patterned after the Hawaii SHIP approach.

Additionally, the Legislature is poised to act. There has been extensive dialogue between the Legislature and the governor's office. Assuming more importance than the provisions of any plan appears to be the underlying financing mechanism.

The Coalition concluded major deliberations on October 22, 1992. The Medical Society of New Jersey (MSNJ), the New Jersey Hospital Association, the New Jersey Nurses Association, New Jersey Business and Industry, HEAL Coalition, Blue Cross and Blue Shield, U.S. Healthcare, Prudential, and other health care professional organizations drafted a proposal calling for the restructuring of the health care system. Plans for a more competitive health care system financed by public/private partnership were outlined. It was stressed that health care should be delivered by a variety of practice settings with decreased reliance on hospital emergency rooms. Minimum regulatory activity with maximum encouragement for hospitals to set their own charges was emphasized.

Guaranteed access to a basic health care package for those who cannot afford their own insurance and are not eligible for Blue coverage, Medicare, or Medicaid was put forward. "Charity care" would be paid by a state subsidy administered through a sliding fee scale based on income and delivered to managed care coverage and networks.

There would be maximized use of federal matching dollars in Medicare and Medicaid reform.

MSNJ was instrumental in having included substantial medical malpractice reform. The features included the elimination of joint and several liability, amendment of the prejudgment interest rule, and the requirement for filing a certificate of merit, and consideration for statute of limitations requirement and practice parameters usage as a defense.

The insurance package offered would reduce regulatory control and would require that no more than 25 percent of costs were administrative. Guaranteed issue, renewal, and portability were part of the package.

We were highly vocal on the issue of provider tax and this issue appears as a suggestion on the final matrix.

The Coalition felt the long-term solutions of financing lay in a dedicated income tax. Since this would require a ballot referendum, an interim source of financing was suggested that would essentially restore the 1 percent previously eliminated by the sales tax. For a long time, the Coalition debated whether to offer any financial suggestions to the Legislature or the governor's office. In the end, the Coalition decided to bite the bullet; to say that recommending a sales tax was negatively received would be an understatement.

Alternative mechanisms discussed included the use of the unemployment insurance trust as a temporary funding source and the health promotion taxes.

On October 28, 1992, Governor Florio introduced a program, NJ SHIELD. NJ SHIELD is based on the Hawaii SHIP program. I have obtained a copy of the program, and noted that it was created to meet the needs of those in the state not eligible for Medicare or Medicaid and not covered by employers' health plans. It covers about 35,000 people in Hawaii—about 1/25th the size of any New Jersey program, assuming that the "client base" remains the same. The governor did not mention that only 12 physician visits are allowed each year; hospitalization is limited to five days a year and $2,500 a person; two days are allowed for maternity care and elective surgery; and high-cost tertiary care is excluded.

Nevertheless, the NJ SHIELD plan would provide subsidized health insurance for uninsured, temporarily unemployed, or part-time seasonal workers.

The state would pay a projected $450 million to the health plan. But no source of revenue has been identified to replace the current $843 million program—that will be the sticky wicket.

Policyholders will pay on a sliding income scale with many copayment features. The plan is to start in January 1994. There is no explanation for what to do in the interim or how to get from here to there.

MSNJ's direction is toward a more privatized, market response, a physician-directed (managed care) program that obtains reimbursement for physicians not previously obtained and would avoid a provider tax or other onerous features.

I promise you, that myself, supporting staff, and lobbyists will work diligently on your behalf. □

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A Simple Method for Measuring Ventriculomegaly in Neonates

Vidor Bernstien, MD

The author presents a simple, easy-to-use, noninvasive, and easily reproducible method for measuring ventriculomegaly in the premature neonate. Neonatologists, as well as neurologists and neurosurgeons, have come to rely upon this method of measuring the ventricles in neonates.

This paper describes a simple, noninvasive, accurate, and easily reproducible method for measuring the ventricles in neonates, utilizing the transfontanel ultrasound method.[1,2]

One of the problems confronting neonatologists when managing neonates, particularly premature neonates, is the enlarging ventricular system. Whether this is due to a congenital defect, an intraventricular hemorrhage, or another cause is important; however, determining when to intervene with medication and/or surgery can be a more significant problem. This extends to the postintervention time for following the adequacy of the treatment. Assessing the size of the ventricles, or the change in the size of the ventricles, can be difficult.

Previous techniques for measurement using real-time ultrasound equipment primarily have utilized the axial plane. It is somewhat cumbersome to measure the ventricles through the intact cranium; some techniques have used the anterior fontanel. Most procedures have utilized complicated computations and/or multiple measurements of the ventricles and surrounding parenchyma.[3-5]

There is a simple, accurate, and effective method to assess the changes in ventricular size. This method has the advantages of being easily performed by the sonographer doing the neurosonography, and of being easily reproducible in the clinical setting. The vast majority of examinations have been performed at my institution by the sonographer using portable equipment at the bedside of the patients, in the intensive care nursery.

The physician calculates a ratio between the ventricles and the cranial vault, the ventriculo/cranial ratio (V/C ratio).

Using the usual routine examination technique for neurosonography of the neonatal brain through the anterior fontanel, the physician selects the coronal view through the occipital horns just distal to the choroid plexus as the standard view. The occipital horns almost invariably are the first area to enlarge, and the last to return to normal size. With the image frozen on the screen, the electronic calipers are utilized to measure the transverse distance of the ventricles (each side separately) at the widest point (Figures 1-4). Then a horizontal line measurement between the cranial walls is taken, at the same level as the ventricular measurements. The ventricular measurements are divided by the cranial measurement; the V/C ratio is calculated for each side and entered on a line chart (Figure 5) with the appropriate date. Followup examinations are charted on successive lines; the changes in ventricular size are easily identifiable from this format.

This technique adds only one or two minutes to the routine neurosonographic examination. The calculations are completed after the films are developed.

The major utility of this technique is not to determine whether the ventricular system is "normal," but rather to determine if it is enlarging. Premature neonates, the vast majority of our patients, are not "normal" in the same category as full-term neonates. This technique gives the clinician an idea of what is "happening" with the ventricular system; a means to determine whether the ventricular system is enlarging, or, after intervention has occurred, whether the treatment is effective. The "mean baseline" for each patient is the first examination; however, there is a time when the ventricle no longer can be measured (it has become too slit-like) and then is considered to be "within normal limits." As a corollary, the physician can measure the V/C ratio in intrauterine instances to try to de-

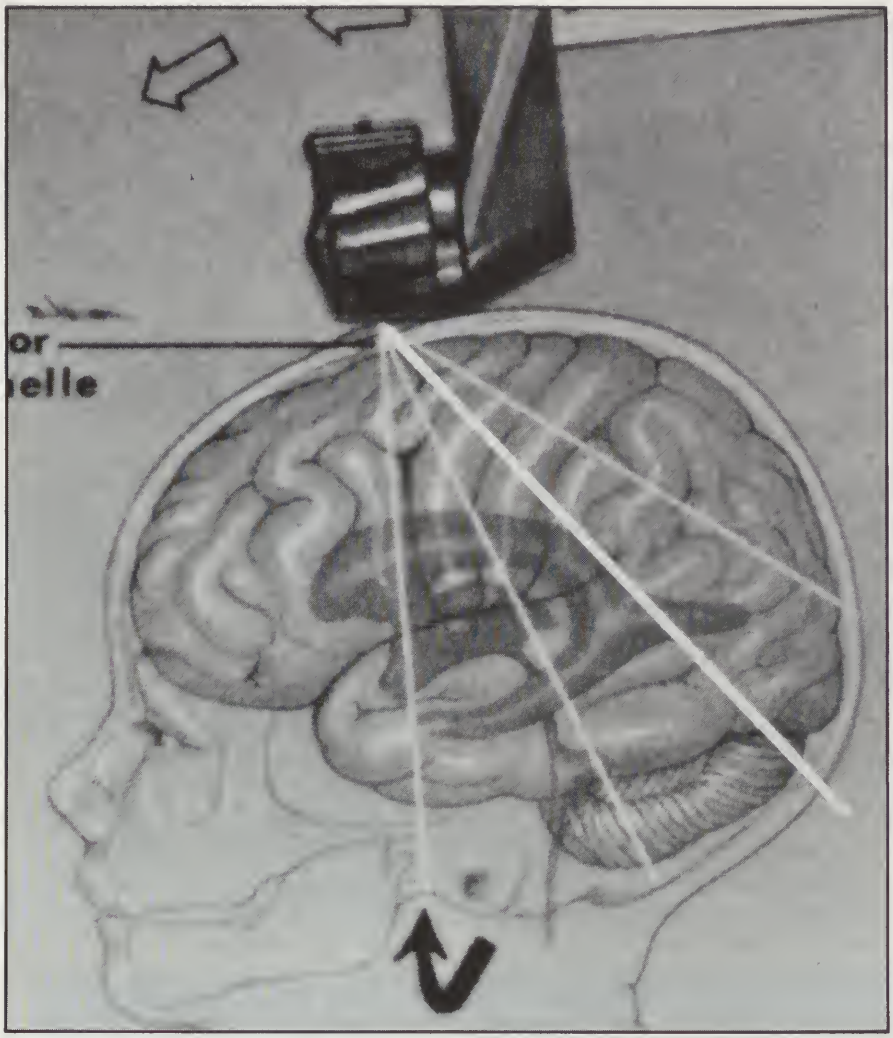


Figure 1. Routine angles for neurosonography.

velop some relationship between the second and third trimester gestation and the premature neonate of similar gestational age. This also may prove to be a method for dating the premature neonate.

It seems obvious that by using this method, physicians are measuring changes in cerebral parenchyma. As the ventricular system enlarges (with a concomitant diminuition of the cerebral parenchyma), the ratio will increase; the converse also is true.

Neonatologists, neurologists, and neurosurgeons have come to rely upon this method for following patients. As long as the anterior fontanel remains patent, this ratio can be calculated. A computed axial tomography (CAT) scan also may provide a similar determination; however, the radiation as well as the inability to do the examination in a portable way makes it much less desirable. During the followup period, the fontanel may close, and would necessitate using the CAT scan, if further followup is necessary.

Neurosurgeons and neonatolo-

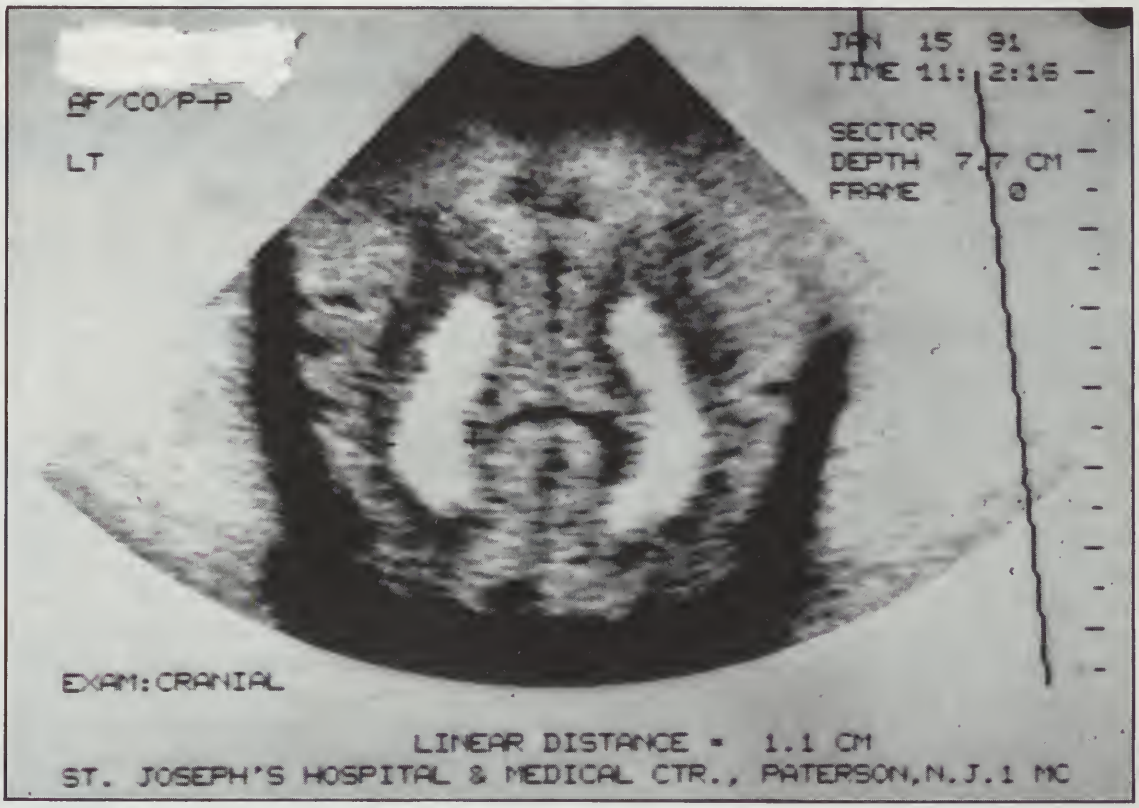


Figure 2. Measurement of the left lateral ventricle.

gists have been using this measurement in order to determine the need for, as well as the timing of, shunt placement. Followup examinations show whether the shunt procedure is working properly. Pharmacological therapy also has been assessed, again by using this simple methodology.

Determination of "normal" parameters is difficult, since the size and configuration of the ventricles varies considerably in the neonatal period infant. Physicians can consider a ratio of less than 1 as within normal limits, however, future investigations may show this to be generous. Clinicians have not tried to correlate the measurement with "normal" neonates, but they plan to do so in the near future. This procedure has been reserved for



Figure 3. Measurement of the right lateral ventricle.

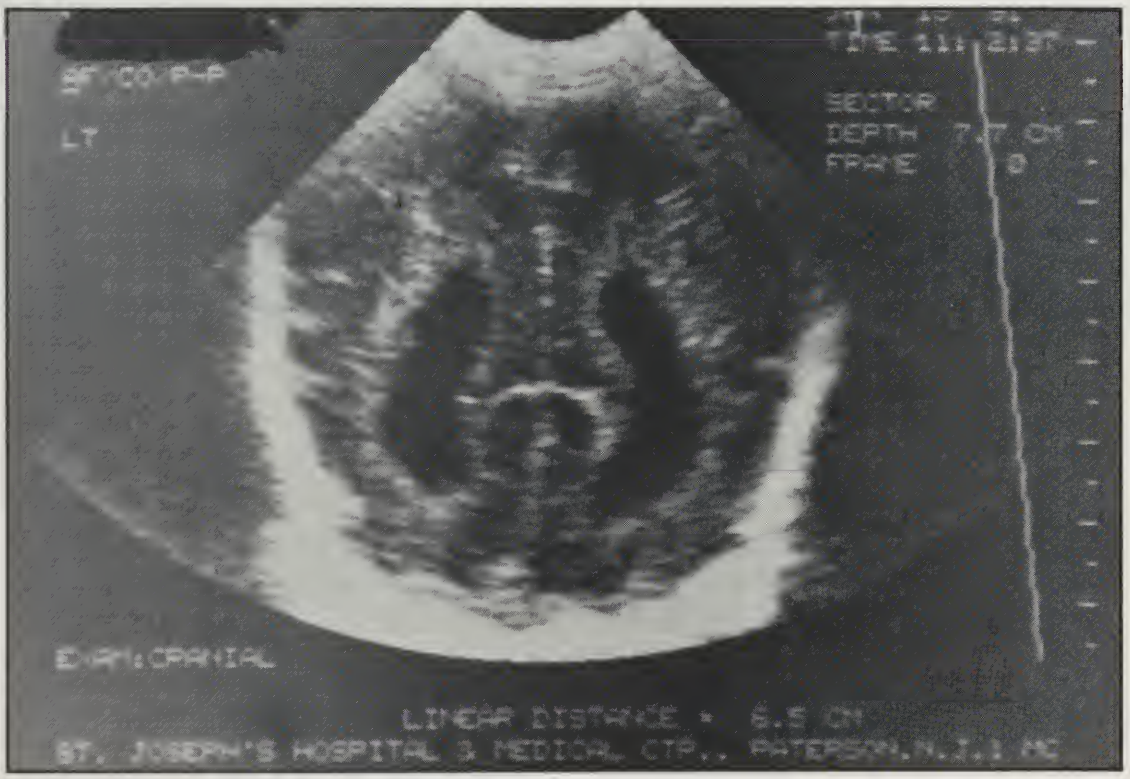


Figure 4. Measurement of the cranial dimension.

NAME: _____

MR: _____ DOB: _____

V/C RATIO

LEFT	DATE	RIGHT

Figure 5. The line chart.

baseline and followup studies in problem cases of premature neonates. ■

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Dr. Bernstien is affiliated with the Department of Radiology, Saint Joseph's Hospital and Medical Center, Paterson.

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Address reprint requests to Dr. Bernstien, Saint Joseph's Hospital and Medical Center, 703 Main Street, Paterson, NJ 07503.



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Inpatient Triage for Out-of-Hospital Disasters

Martin L. Evers, MD
Joseph J. McHugh, MD

Due to Operation Desert Storm, St. Francis Medical Center established an inhouse triage system to make bed space rapidly available during out-of-hospital disasters. The authors discuss the use of physician bed monitors and discharge criteria and suggest the importance of hospital readiness.

In 1980, the United States Department of Defense proposed a plan to identify 50,000 beds in civilian hospitals that could be used on short notice for the treatment of military casualties. These beds also were to be available if a regional disaster overwhelmed an area's ability to care for victims.[1] This system is known as the National Disaster Medical System (NDMS). The intent is that these patients can be transported to a participating hospital out of the region. The plan calls for hospitals that decide to participate voluntarily to be able to "free up" a minimum of 50 beds at short notice for the treatment of military or disaster victims.[1]

The plan is supported by the American Hospital Association (AHA), the American Medical Association (AMA), and the Joint Commission on Accreditation of Health Care Organizations (JCAHCO). However, the system never has been tested since it was started in 1980. In the recent Middle East conflict, the military saw the potential for many significant injuries because of Iraq's military power with conventional and chemical weapons. With the relatively small number of military hospital beds available to American troops, the military requested that participating NDMS facilities be prepared for incoming wounded on short notice.

It was this potential that prompted St. Francis Medical Center to adopt a system to "free up" as many patient beds as needed, as quickly as possible. Articles have been written about triage at the disaster scene[2-8] and in the emergency department,[7-8] and about general disaster preparation;[9] little has been written about how a hospital should prepare to receive disaster victims.

In any disaster, it is important to try for "business as usual," since it has been shown that health care workers perform best when they are asked to do their usual activities rather than to learn a new set of duties.[10] Our hospital has a mechanism for allocating intensive care unit (ICU) beds and cardiac care unit (CCU) beds, which involves having potential patients to these units screened by physicians, called bed monitors, and admitted only if they meet admission criteria. These bed monitors also review the records of incumbent critical care patients at the request of the unit head nurses to determine whether these patients can be discharged from the unit, freeing up beds for incoming patients. When the transfer is appropriate, the bed monitor discusses the case with the private attending and usually can convince that physician to transfer the patient to a regular floor bed, with the private physician accepting the resultant liability. In those rare cases where the private physician refuses to transfer the patient from critical care, the hospital has empowered the bed monitor to override the private attending and to transfer the patient to a regular floor. The bed monitor must be convinced of the stability of the patient, because he will be responsible, from a medicolegal point of view, should the patient deteriorate after transfer from critical care to the regular floor.

This mechanism—for transfers from critical care—is supplemented at the time of a disaster by a similar mechanism for the early discharge of patients from the regular floor. The potential medicolegal liabilities also are similar. It is the responsibility of the discharging physician, the private attending, or the bed monitor to assure proper outpatient followup for the individuals sent out of the facility.

METHODS

Facility. St. Francis Medical Center is a 443-bed community teaching hospital in Trenton.

Table. ***Primary criteria for potential discharge.***

- Stable patients on long-term intravenous antibiotics
- Elective admissions
- Nursing home candidates
- Terminal care patients
- Nonsuicidal, nonhomicidal psychiatric patients

There are 11 critical care beds, 13 coronary care beds, 12 telemetry beds, 25 pediatric beds, 22 obstetric beds, and 24 acute psychiatric beds. The remainder are general medical-surgical beds. The hospital has a cardiac catheterization laboratory, but does not perform cardiac angioplasties or open-heart surgery.

The hospital supports three residency programs. The medical residency is shared with another facility, which shares equally a group of 60 residents. The surgical residency is entirely in-house and has 14 residents. The psychiatry residency is shared with an outside facility and has a total of 19 residents.

Disaster plan. When an external disaster occurs, the telephone operator is notified of the nature of the disaster, location, estimated number of victims, estimated time of arrival, and method(s) of arrival. The operator notifies the disaster chairperson, who then notifies the chief operating officer or designate, to activate the disaster plan. In addition to preparing the emergency department, the disaster chairperson also directly notifies the inpatient bed monitors—one each for medicine and surgery.

Our designated bed monitors, by design, are individuals already performing a similar role in the facility. As a general rule, they are board certified in their particular specialties, and have critical care and/or emergency medicine experience. Furthermore, they have a working knowledge of general triage precepts. In performing their function, they have been given full authorization to call in additional physicians to assist as required.

DISCUSSION

Criteria. The criteria (Table) used for early hospital discharge of patients to make beds available for disaster victims must not cause harm to the individuals discharged from the facility. A preliminary list of potential discharges can be created by the nursing department,[11] with the final decision made by the attending physician and/or the designated bed monitor.[12] As Leonard wrote, "Patients who can be discharged easily include those who were admitted for diagnostic workup or elective surgery, those who can be given home care, and probably those who are to be discharged within 24 hours."[12]

Stable patients receiving long-term intravenous antibiotics, for years, have been treated at home with visiting nurses providing regular care.[13-16] In our community, this service is provided by a visiting nurse service autonomous from the hospital. In some areas, this may be provided by a hospital-affiliated service or private commercial health care agency. Therefore, these individuals could be discharged early and cared for at home. Furthermore, with oral antibiotics suitable for many infections, patients who can be changed safely from intravenous to oral medications should have it done to facilitate early discharge.

Many patients admitted for elective procedures in surgery, cardiac catheterization, or endoscopy, as well as those in the hospital for workup only, can be safely sent home, and rescheduled for a later date.[12] This would "free up" many beds for possible use by disaster victims.

Most community hospitals have a group of inpatients waiting for nursing home placement, or receiving terminal care. Those patients awaiting nursing home placement pose problems because families rarely will take them home, and nursing homes are slow to accept them. In times of disaster, however, where the need for acute care beds is large, these individuals must be expeditiously placed with minimal delay. Patients admitted for terminal care, with a "do not resuscitate" order in place must be sent home when possible. For both of these patient groups, the cooperation of others directly affected is required, if transfer is to occur.

In facilities with psychiatric inpatients, additional bed space may be created by discharging those individuals who neither are suicidal nor homicidal to outpatient care. This will yield additional acute care bed space, as well as provide places for individuals who suffer acute psychiatric problems as a direct result of the disaster.

This list is not inclusive. There will be patients who are stable, yet do not meet any of these criteria, and no longer require inpatient care; on an individual basis, they too will be discharged.

Use of criteria. The nursing staff uses this criteria to evaluate inpatients for potential discharge. The bed monitors review each case, and decide which individuals are to be sent home. Discharge is expedited by having the attending physician of record and/or the housestaff facilitate the paperwork and arrangements.

Importance of plan. It is difficult for an individual physician to assess the efficiency of his medical care. In the time of a disaster, the need for timely movement of patients is accentuated. The individuals most qualified to do this are physicians with the background and knowledge to act in an expeditious manner. This led St. Francis Medical Center to use physician bed monitors, with the consent of the medical staff. Our experience with bed monitors in the critical care setting has been effective. This has led to extending their authority to all areas of

the hospital during disaster situations. Instead of causing discontent and antagonism between physicians, it has led to more open discussion about patient care and the use of hospital resources, with improvement in both areas.

Based on our own experience, we would recommend that other facilities consider an approach similar to ours. This is especially important in NDMS-affiliated facilities, where the demand for hospital beds could present itself suddenly. It would be of value for physicians with triage experience from the military to provide their expertise in the development of these disaster plans. ■

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Dr. Evers is affiliated with the Department of Internal Medicine and Dr. McHugh is affiliated with the Department of Emergency Medicine, St. Francis Medical Center, Trenton.

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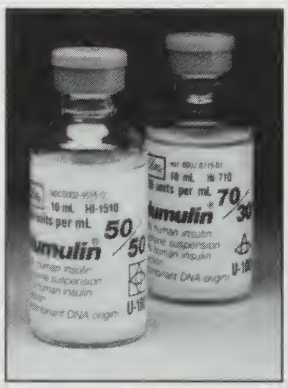
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Screening for Breast Cancer Among New Jersey Women

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The American Cancer Society, New Jersey Division, the New Jersey Radiological Society, the New Jersey State Department of Health, and clinics and hospitals throughout the state participate in a breast cancer detection awareness program, to increase women's awareness of their risks for breast cancer.

Breast cancer is a major cause of illness among women and is second only to lung cancer as a cause of death in this population. In New Jersey, an average of 4,600 new cases of breast cancer are diagnosed each year among women, and approximately 1,600 deaths per year are attributed to the disease.[1] Nationwide, an estimated 175,000 new cases of breast cancer will be diagnosed in women this year, and approximately 44,500 women will die from the disease.[2]

The most recent analyses of breast cancer among New Jersey women show that, from 1979 to 1985, white females exhibited an age-adjusted incidence rate for breast cancer of about 100 per 100,000 women, with a corresponding mortality rate of 32 per 100,000 women. In comparison, black females showed an age-adjusted incidence rate of 83 per 100,000 women, with a mortality rate identical to that of white females (Figure 1). Regardless of the stage at diagnosis, white women had consistently higher rates of five-year relative survival than did black females (Table 1 and Figure 2).[1,6]

Studies show that the single most effective method for the early detection of breast cancer is screening mammography. Women who engage in a combination of regular breast self-examination (BSE) along with routine clinical breast physical examination (BPE) and screening mammography have the advantage of detecting and seeking treatment for breast cancer while they still are in the early stages, when chances for survival are much better.[3-5] However, despite this information, many women have not received screening mammography.

Efforts to increase the number of women screened for breast cancer have intensified through organized, nationwide breast cancer screening programs such as the Breast Cancer Detection Awareness Program (BCDAP). BCDAP was initiated in 1973 by the National Cancer Institute (NCI) and the American Cancer Society (ACS) as a means of demonstrating to the medical profession and to the public the importance of education and periodic screenings in the early detection of breast cancer. This paper describes and summarizes the New Jersey BCDAP findings from 1987 through 1990, and provides a provisional estimate of screening practices of New Jersey women, as self-reported during the 1990 New Jersey Behavioral Risk Factor Surveillance Survey (BRFSS) in New Jersey.

METHODS

To promote facility involvement in the 1987 to 1990 NJ BCDAP, an annual request for application to participate was distributed statewide to all hospitals, diagnostic and treatment centers, local health departments, and voluntary agencies. Institutions participating in BCDAP received ACS recognition and free media attention to mammography services as a result of ACS's campaign to promote the early detection of breast cancer, which began in March and continued through May of that year. Institutional

Table 1. ***Relative survival for breast cancer cases diagnosed, 1979 to 1985.***

	Five-Year Relative Survival by Stage of Disease			
	Local	Regional/ Distant	Unknown	All Stages
Black Females	76.63%	40.50%	42.84%	54.68%
White Females	83.56%	55.12%	50.71%	67.12%

Table 2. *New Jersey breast cancer detection awareness program; participation in screening, 1987 to 1990.*

BCDAP Year	Total Participants	Cases Reported from BPE*	Cases Reported from Mammogram	Total Reported from Both Methods
1987	5,092	14	22	36
1988	6,012	28	18	46
1989	4,425	3	21	24
1990	4,930	9	8	17
Total	20,459	54	69	123

*BPE: Breast physical examination

Table 3. *Mammography experience of New Jersey women reported on BRFS by weighted percentage responding.*

Age of Women Surveyed	Number	Women Reporting Having Received Mammography
18-34	69	12 (15%)
35-39	19	10 (51%)
40-49	33	27 (85%)
50+	102	57 (55%)
Refused to state age	6	2 (38%)
Total	229	108 (47%)

participation in BCDAP was managed by ACS.

A standardized participant intake form was used by all reporting institutions, and data collection was limited to screening utilization and service outcomes only. Participants were recruited from the population at large and received free breast cancer education, BPEs, and low-cost mammograms. Registration was open to women who were 35 years of age or older, had no prior history of breast cancer, never had a mammographic examination, and were neither pregnant nor nursing. Summary data collected from participating institutions then were included in a statewide database. Data collected for BCDAP in New Jersey for the four-year period were: reporting institutions; number of participants registered; utilization of screening procedures, both physical examination and mammography; and results of physical and mammographic examinations. Data were tabulated for each year and compared with the data from the previous years' programs.

Beginning in November 1990, New Jersey began participation in BRFSS, a continuous telephone survey sponsored by the Centers for Disease Control (CDC). BRFSS was designed to be conducted year round, with random digit dialing to New Jersey residences during evening hours and on weekends for the middle two weeks of the month. The questionnaire must be administered only to the proper individual, aged 18 years or older, within the household. Selection of which individual with whom to speak is made via an algorithm chart based on the number of individuals in the household, their rank by descending age alternating by sex, and the last digit of the telephone number dialed. Random sampling continues each month until 125 surveys have been completed, resulting in a sample size of 1,500 samples per year.

In 1990, data were collected during November and December. A revised goal was established for an oversampling of 400 persons for the two-month startup period, with 399 surveys actually completed. The resulting weighted data are presented as a preliminary estimate of mammography and BPE practices as reported by adult women in New Jersey. Of the 399 survey respondents, 229 were women: 69 women were in the 18-to-34-year-old age group, and 19 women were in the 35-to-39-year-old age group where an initial baseline screening mammogram is recommended by ACS guidelines. There were 33 women in the 40-to-49-year-old age group where biennial screening is recommended and 102 women in the over 50-year-old age group where annual mammography is recommended. The data have been weighted for analysis so that individual responses account proportionally for the contribution of their demographic groups, e.g. race, sex, age, income, and education, to the state population distribution.

RESULTS

Data from BCDAP in New Jersey during 1987 to 1990 are presented in Table 2 and in Figure 3. A total of 20,459 women participated and received either a screening mammogram and/or BPE during the four annual BCDAP screenings. It should be

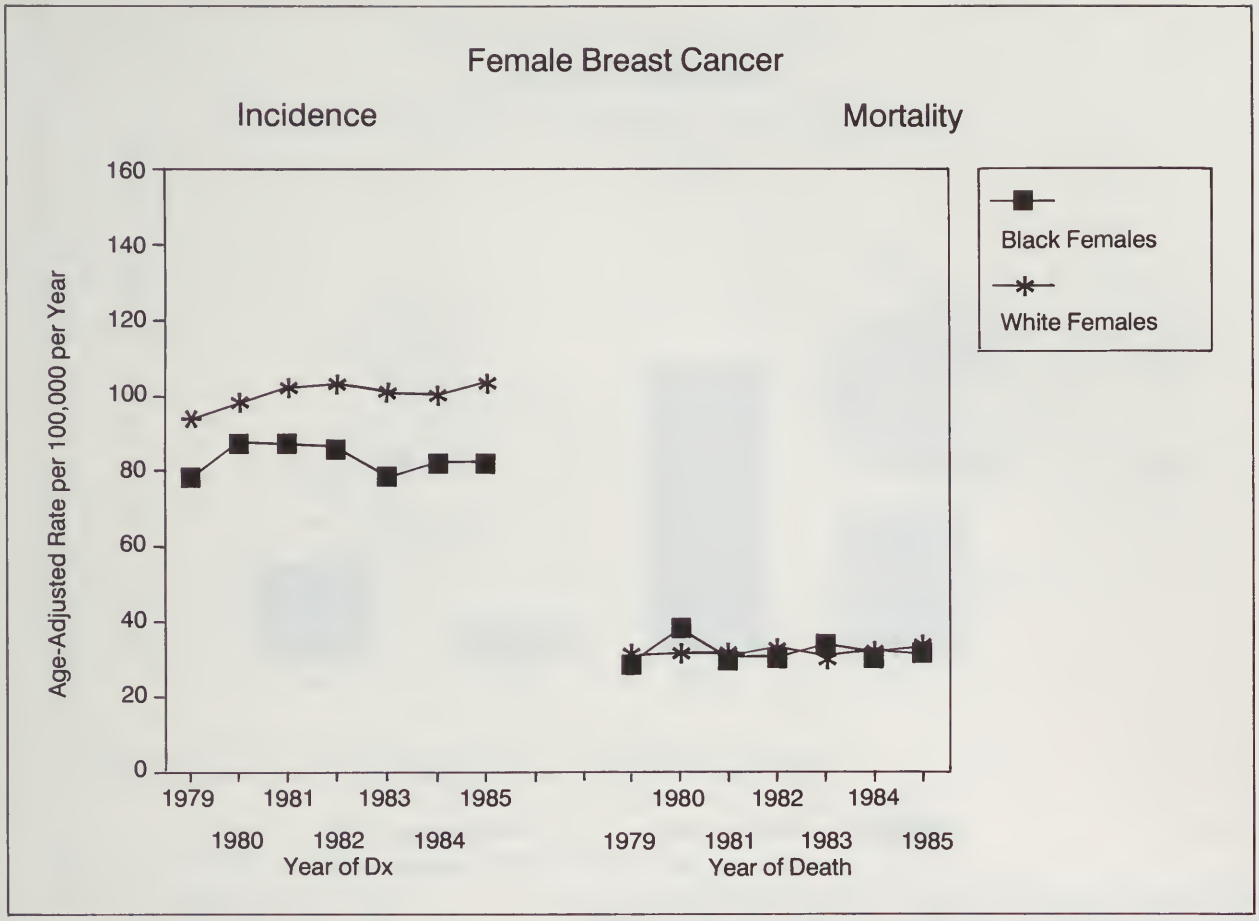


Figure 1. Incidence and mortality of breast cancer for the period 1979 to 1985, age-adjusted to the 1970 U.S. standard population.

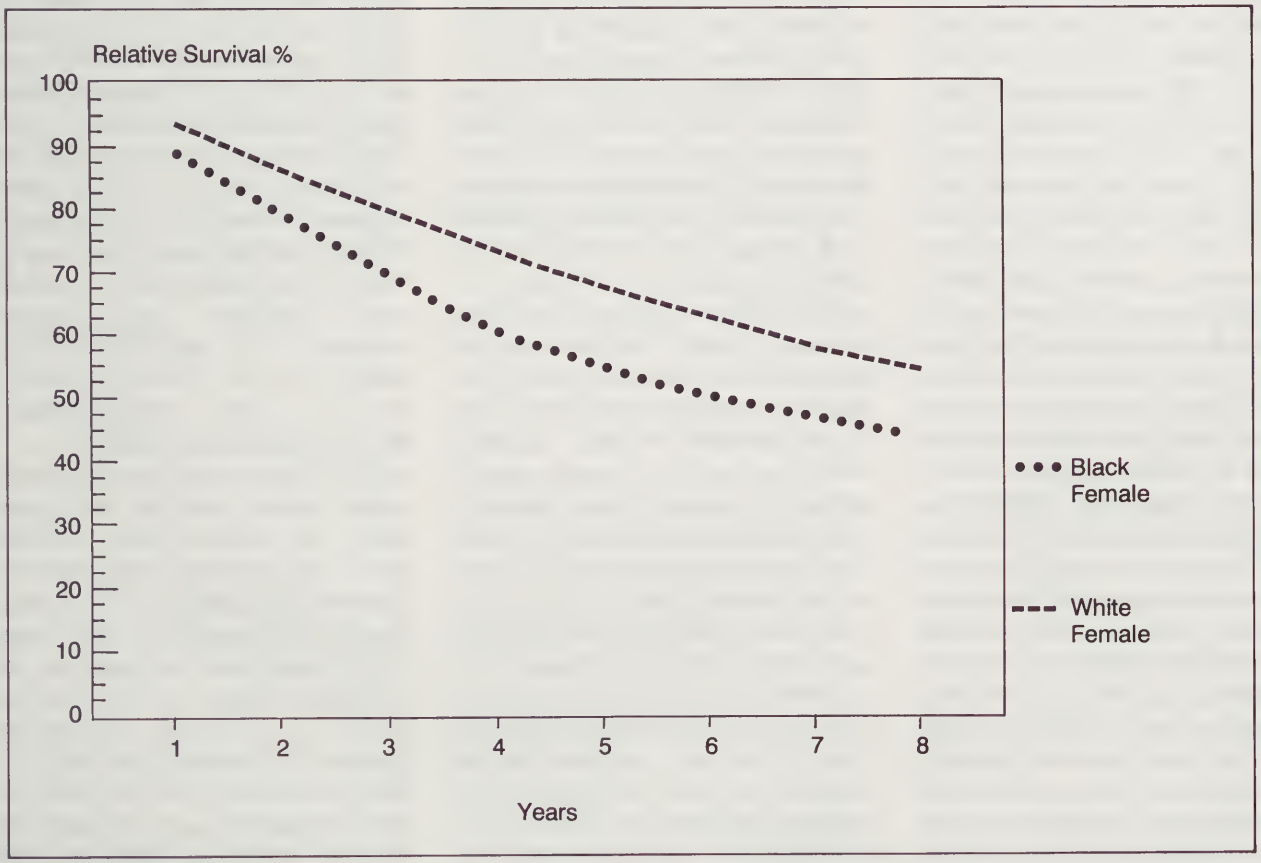


Figure 2. Relative survival curves for breast cancer cases diagnosed, 1979 to 1985.

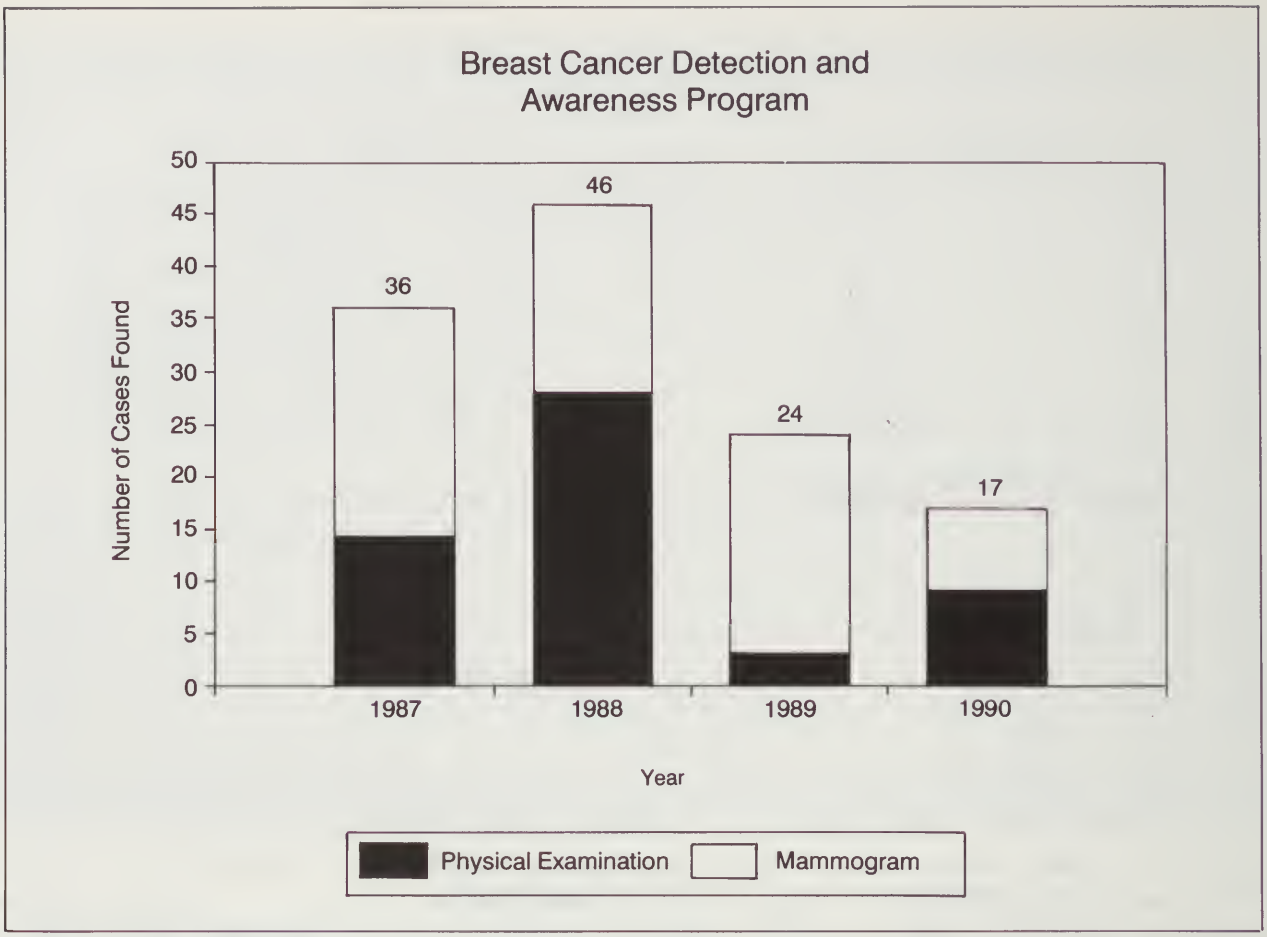


Figure 3. Breast cancer cases detected by method, 1987 to 1990.

noted that the data do not differentiate between numbers of women receiving only screening mammograms, only BPE, or both. A total of 123 breast cancer cases were identified as a result of the 1987 to 1990 New Jersey BCDAP. Data on screening results for positive breast cancer indicated that 56 percent of the cases were detected from BPE. The proportion of women for whom followup results of positive mammograms were reported increased from 62 percent in the 1987 BCDAP to 100 percent in each of the following three years.

Results from the BRFSS in New Jersey indicated that nearly half (47 percent, n = 108) of the adult women (n = 229) surveyed in New Jersey have been screened for breast cancer by mammography. Of these women, 69 percent had been screened within the past year at the time of the survey, and an additional 21 percent had received a mammogram within the past two years (Table 3 and Figure 4). Table 5 provides a breakdown of the source of recommendation for the mammogram, indicating that 63 percent were recommended by the doctor and 27 percent were requested by the woman. The most frequently reported reasons for having a mammogram were as a result of a routine examination and doctor recommendation (Tables 4 and 5).

Of the 18-to-39-year-old women (n = 88), 24 percent reported having been screened. Of these, only 15 percent of the 18-to-34-year-old women (n = 69) had received a mammogram, while 51 percent of the 35-to-39-year-old women (n = 19) reported having mammography. Although a relatively low number of responses in the 40-to-49-year-old age group (n = 33) makes the estimate subject to some uncertainty, 85 percent of the 40-to-49-year-old women reported having received mammography. Of the women aged 50 years and older (n = 102), 55 percent reported having received mammography. It should be noted that among the total group of women aged 50 years and older, only 36 percent of the mammograms performed were within the recommended yearly frequency, while 83 percent of the total women responding between ages 40 and 49 years reported having received a mammogram within the recommended biennial frequency. Data suggest that compliance with recommended ACS guidelines is far better in the 40-to-49-year-old age group than among women aged 50 years and older.

For those women who reported never having received a mammogram, the reasons cited as most important were: it was not recommended (27 percent), it was not needed (29 percent), they had never heard of a mammogram (4 percent), reasons of cost or insurance (5 percent), and other reasons (12 percent). A full 23 percent reported that the reasons were unknown or refused to respond to this question on the survey.

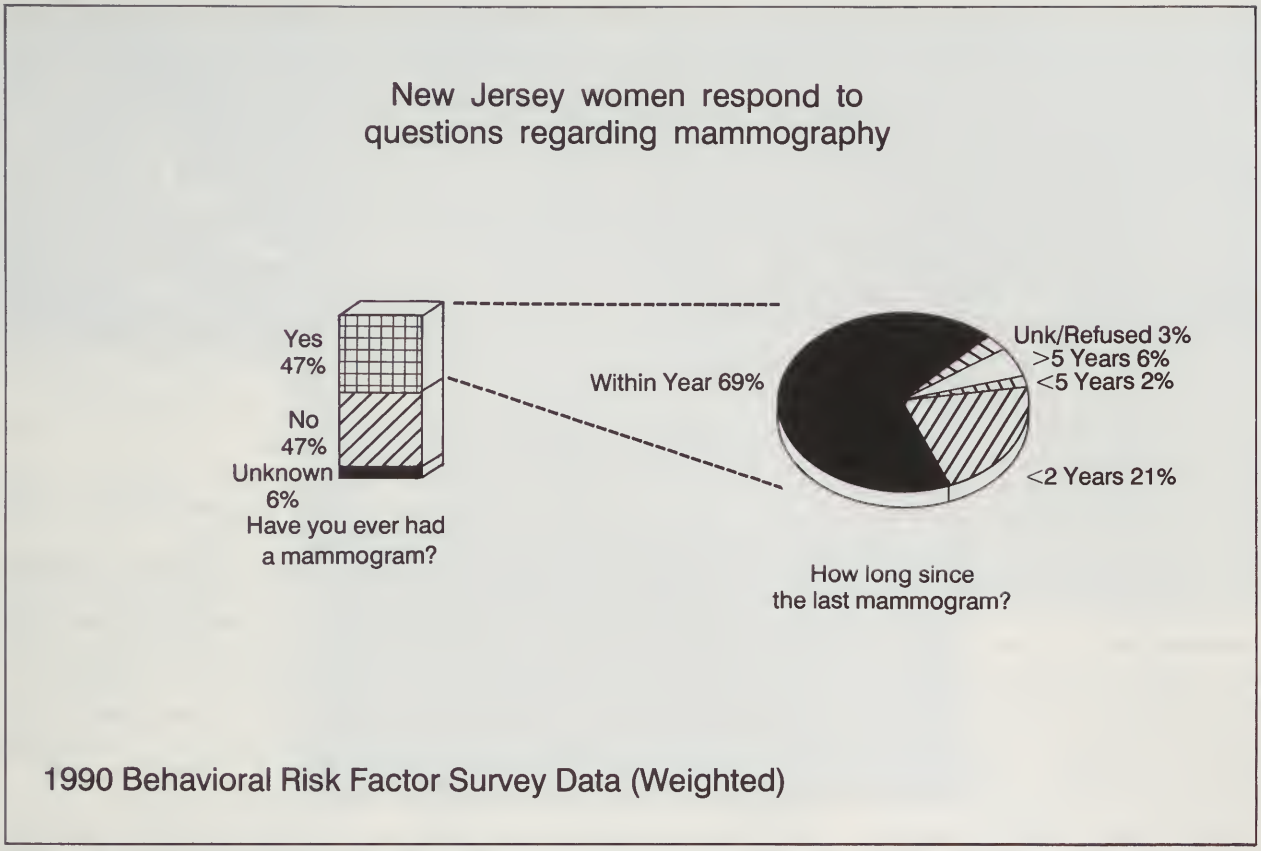


Figure 4. Self-reported mammography status of New Jersey women.

Of the original 229 women sampled, 84 percent (n = 193) reported having received a BPE by a physician or medical assistant. Of these, 73 percent stated that it had been within one year, while an additional 16 percent reported that it had been within two years. Reasons given for having the BPE were: part of a routine examination (93 percent), breast problem (5 percent), and previous breast cancer (2 percent).

DISCUSSION

The American Cancer Society recommends:

1. Monthly self-examination of breasts by women 20 years of age and older to form good health habits.
2. Physical examination of the breasts, by a physician, every 3 years between the ages of 20 and 40, and once a year after age 40.
3. A baseline mammogram for women by age 40.
4. Mammography every 1 to 2 years for women between 40 and 49 years of age, depending on physical and mammographic findings.
5. An annual mammogram for asymptomatic women 50 years of age and older.[2]

In considering the overall success of such programs as BCDAP in New Jersey, several issues emerge. First, BCDAP in New Jersey is an annual, one-week health education and awareness program initiated to complement ongoing statewide efforts by ACS throughout the year and to demonstrate the effectiveness of mass screening programs in detecting breast cancer. Reduction of mortality from breast cancer will be dependent on the ability to provide routine screening programs throughout the year and to increase participation of the target populations. Establishment and appropriate targeting of such programs must address broader health issues, including cost/access issues and other sociodemographic barriers to health care among the female population in New Jersey.

Limitations to be considered in interpreting results of participation in BCDAP in New Jersey are the age distribution of the population in the intervention areas, and the possibility of the heightened awareness of breast cancer risk due to BCDAP media campaigns and to other programs sponsored independently by health care providers throughout the year. The population reached each year by BCDAP was small, only about 0.25 percent of the New Jersey female population aged 35 years and older.

BRFSS results indicate that more programs promoting mammography screening are needed in New Jersey. It appears that most of our efforts should concentrate on improving the level of mammography utilization in the over 50-year-old age group. The poor compliance observed among women 50 years of age and older in the 1990 sample is in stark contrast to the estimates for the 40-to-49-year-old population. The national goal that most nearly relates to BRFSS data calls for 80 percent of women over age 40 to have received a mammogram by the year 2000. An estimated 63 percent of New Jersey women over age 40 already had received

Table 4. *Reasons for mammogram.*

Routine examination	84	(73%)
Symptoms	15	(16%)
Personal history of breast cancer	5	(5%)
Unknown/not sure	3	(4%)
Refused to state reason	2	(2%)

(n = 109, includes one respondent who should not have been asked this question)

Table 5. *Recommended mammogram.*

Doctor recommended	74	(63%)
Self requested	26	(27%)
Third-party recommended	6	(5%)
Did not know who recommended	2	(4%)
Refused to state who recommended	1	(1%)

(n = 109, includes one respondent who should not have been asked this question)

a mammogram by the end of 1990, with 67 percent of these reporting having been screened within the past year, and an additional 22 percent within the past 2 years. The limitations of the 1990 startup BRFSS survey include the small sample size of the targeted population, and the fact that the respondents must be reachable by residential telephone.

BCDAP in New Jersey for the years 1987 to 1990 demonstrated that educational efforts, clinical examinations, and screening mammograms are of value in the detection of breast cancer in women. Ongoing, statewide efforts targeted to those at greatest risk must be supported by the health care community. Primary care physicians, obstetricians/gynecologists, other care providers, and programs serving women should promote mammography screening in tandem with BPE examination and self-breast examination, in accordance with ACS guidelines.

CONCLUSION

All women must be educated to greater awareness of their risk of developing breast cancer and of the advantages of early detection through mammography screening, routine medical examinations, including BPE and BSE. Physicians and public health professionals must make greater efforts to encourage women to have mammograms, and currently available opportunities must be expanded to provide access to care for all women, including women with lower socioeconomic and educational levels. ■

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Dr. Petrone, Mr. Lewis, Ms. Lenhardt, and Ms. Harlan are affiliated with the New Jersey State Department of Health. Ms. Greene is affiliated with the American Cancer Society, Public Education Committee.

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Address reprint requests to Dr. Petrone, New Jersey State Department of Health, CN 369, Trenton, NJ 08625-0369.



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Childhood and Young Adult Cancer in New Jersey

Dona Schneider, PhD, MPH
Michael R. Greenberg, PhD
Milton H. Donaldson, MD
Toshi Abe, MSW
Daiwoo Choi

Cancer incidence rates for 0 to 24 years of age were examined for New Jersey for 1979-1985. New Jersey rates generally were higher than the comparison states. They were most like those of Connecticut, the state most similar in demographics, geography, and degree of urbanization.

The Surveillance Epidemiology and End Results (SEER) Program of the National Cancer Institute (NCI) estimates that 6,550 new cases of cancer in children under 15 years of age occur in the United States each year. Additionally, 2,175 American children under 15 years of age die annually from the disease.[1] Nationwide, the largest number of new cases in children under 15 years of age occur as leukemias, followed by brain/central nervous system (CNS) cancers, and lymphomas (30, 19, and 12 percent, respectively).[2-4]

It is estimated that 12 percent of all new cases of cancer in American children under 15 years of age have been ascertained since 1973 by the SEER Program.[1] SEER and other population-based registries provide excellent sources of data for descriptive epidemiologic studies, yielding information on the peculiarities of cancer incidence and survival by age, gender, and race, as well as clustering of cases in time and space.

Not all SEER data collection areas are state-based registries. For example, Atlanta and Detroit are SEER data collection areas, but Georgia and Michigan are not SEER states. For this analysis, we chose only statewide SEER registry data to compare to New Jersey data. We felt that using statewide registry data was a more reasonable comparison for our statewide registry data than would be limited, metropolitan-area comparisons.

We review the patterns of pediatric (0 to 4 years of age and 5 to 14 years of age) and young adult (15 to 24 years of age) cancer incidence in New Jersey and four SEER states (Connecticut, Iowa, New Mexico, and Utah). These states are characterized by differences in demographics, lifestyle, religion, and degree of urbanization. Because of these differences, we would expect New Jersey data to reveal pediatric and young adult cancer incidence patterns that are more similar to Connecticut's than the other states. We would expect New Jersey patterns to be similar to those of Connecticut because both states share the characteristics of being Northeast states, and are highly urbanized, diverse in (racial/ethnic) population, and affluent (the two highest per capita personal income states in 1990). By comparison, Iowa, New Mexico, and Utah are less urbanized and their populations are less diverse and affluent.

DATA AND METHODS

The New Jersey State Cancer Registry (NJSCR) has been in existence as a population-based registry since 1979. New Jersey was part of the SEER network from 1983 to 1990. Initially, its directive was to collect SEER data items for all cases, starting with 1979; later, the SEER coverage area was reduced to four counties (Passaic, Hudson, Union, and Essex). We reviewed NJSCR data quality for pediatric and young adult cancers and estimated ascertainment to be 93 percent with an error rate for demographic and diagnostic information at 1 percent.[5] Our ascertainment figure is conservative as we used more liberal case definitions than those of the SEER guidelines. This means that ascertainment is likely greater than our 93 percent estimate, testimony to the excellent data quality of NJSCR.

Other statewide cancer registries that participate in the SEER Program are the registries of Connecticut, Iowa, New Mexico, and Utah. These states were SEER participants for the entire time period of this study and collected SEER data under the same set of guidelines. These similarities of data collection allow for reliable comparison of data between states.

The incidence data from the Connecticut, Iowa, New Mexico,

Table 1. *Age-adjusted cancer incidence rates with 95 percent confidence intervals, 0 to 24 years of age, New Jersey and selected states, 1979-1985.*

Male cancer diagnosis	New Jersey			Utah			New Mexico			Iowa**			Connecticut		
	Rate	LL	UL	Rate	LL	UL	Rate	LL	UL	Rate	LL	UL	Rate	LL	UL
Brain/CNS	3.08	2.74	3.45	*2.07	1.59	2.69	2.23	1.66	2.94	2.92	2.46	3.45	2.36	1.96	2.82
Bone/soft tissue	2.29	1.99	2.64	*0.69	0.42	1.08	2.26	1.65	3.03	2.04	1.67	2.49	2.06	1.67	2.55
Leukemia	4.33	3.94	4.75	*2.76	2.24	3.43	3.41	2.68	4.33	3.51	3.00	4.10	*3.03	2.79	3.91
Lymphoma/ Hodgkin's	3.13	2.79	3.51	2.16	1.60	2.85	*1.40	0.93	2.03	*2.14	1.75	2.62	3.22	2.75	3.77
Lymphoma/ non-Hodgkin's	1.59	1.36	1.86	*0.90	0.57	1.33	*0.80	0.46	1.27	1.71	1.36	2.13	1.35	1.04	1.58
Male genital	3.13	2.79	3.51	2.22	1.65	2.93	*1.83	1.27	2.54	3.04	2.57	3.60	2.84	2.40	3.36
Digestive	0.84	0.67	1.05	0.72	0.44	1.11	0.62	0.33	1.07	0.63	0.42	0.90	0.70	0.49	0.98
Other	4.27	3.84	4.97	3.64	2.82	4.72	3.62	2.64	4.97	3.68	2.97	4.54	3.31	2.83	3.88
Total	22.66	20.12	25.74	15.16	11.33	20.14	16.17	11.62	22.18	19.67	16.20	23.83	18.87	15.93	22.85

Female cancer diagnosis	New Jersey			Utah			New Mexico			Iowa**			Connecticut		
	Rate	LL	UL	Rate	LL	UL	Rate	LL	UL	Rate	LL	UL	Rate	LL	UL
Brain/CNS	2.61	2.30	2.96	1.87	1.38	2.46	*1.19	0.77	1.75	2.13	1.74	2.60	2.55	2.08	3.11
Bone/soft tissue	1.68	1.43	1.96	1.16	0.78	1.66	1.68	1.17	2.34	1.39	1.07	1.80	2.08	1.66	2.60
Leukemia	3.70	3.33	4.12	*2.33	1.83	2.96	*2.46	1.82	3.24	2.81	2.37	3.33	2.82	2.35	3.39
Lymphoma/ Hodgkin's	2.82	2.49	3.20	*1.21	0.81	1.74	*1.52	1.03	2.17	2.81	2.34	3.38	3.23	2.73	3.83
Lymphoma/ non-Hodgkin's	0.57	0.42	0.75	0.56	0.30	0.93	0.48	0.23	0.88	0.67	0.45	0.96	0.82	0.57	1.13
Female genital	11.83	11.11	12.59	*1.28	0.86	1.83	*1.98	1.41	2.69	#17.06	15.90	18.28	#19.83	18.48	21.26
Breast	0.43	0.30	0.58	0.19	0.06	0.44	0.26	0.08	0.60	0.31	0.17	0.52	0.32	0.17	0.55
Digestive	0.81	0.64	1.01	0.55	0.31	0.91	0.33	0.13	0.68	0.52	0.33	0.77	0.62	0.40	0.91
Other	5.55	4.93	6.26	6.72	5.46	7.29	4.72	3.45	6.32	4.82	4.00	5.82	4.44	3.83	5.15
Total	30.00	26.95	33.43	*15.87	11.79	20.22	*14.62	10.09	20.67	32.52	28.37	37.46	36.71	32.27	41.93

**Includes 1979-1986.
*New Jersey rate is significantly higher.
#New Jersey rate is significantly lower.
LL: Lower limit 95 percent confidence level.
UL: Upper limit 95 percent confidence level.

and Utah registries were received as aggregate data. Connecticut, New Mexico, and Utah included seven years of data, 1979 to 1985; Iowa included 1979 to 1986. NJSCR data were aggregated by age, gender, race, and cancer type to conform to the data from the four comparison states. Nine specific cancer types were selected and another category, other, was created to account for the remaining cases.

Age-adjusted rates were calculated by gender for each of the cancer types based on five-year age groupings (0 to 4 years of age, 5 to 9 years of age, 10 to 14 years

Table 2. *Age-adjusted cancer incidence rates with 95 percent confidence intervals, 0 to 24 years of age, New Jersey and selected states, 1979 to 1985.*

White male cancer diagnosis	New Jersey			New Mexico			Iowa**			Connecticut		
	Rate	LL	UL	Rate	LL	UL	Rate	LL	UL	Rate	LL	UL
Brain/CNS	3.27	2.89	3.72	2.27	1.62	3.09	2.95	2.49	3.49	2.74	2.24	3.34
Bone/soft tissue	2.35	2.02	2.72	2.37	1.69	3.22	2.06	1.67	2.56	2.19	1.75	2.74
Leukemia	4.53	4.07	5.04	3.31	2.55	4.31	3.58	3.05	4.19	*3.27	2.72	3.92
Lymphoma/ Hodgkin's	3.30	2.91	3.74	*1.45	0.94	2.15	*2.12	1.72	2.63	4.01	3.38	4.74
Lymphoma/ non-Hodgkin's	1.68	1.42	1.99	0.89	0.51	1.44	1.76	1.41	2.20	1.54	1.18	2.00
Male genital	3.44	3.03	3.90	*1.82	1.23	2.61	3.14	2.65	3.71	3.84	3.24	4.55
Digestive	0.76	0.59	0.99	0.79	0.43	1.32	0.65	0.43	0.93	0.74	0.49	1.09
Other	4.30	3.83	5.06	4.93	2.86	5.42	3.56	2.86	4.40	3.71	3.13	4.39
Total	23.63	20.76	27.16	17.83	11.83	23.56	19.82	16.28	24.11	22.04	18.13	26.77

White female cancer diagnosis	New Jersey			New Mexico			Iowa**			Connecticut		
	Rate	LL	UL	Rate	LL	UL	Rate	LL	UL	Rate	LL	UL
Brain/CNS	2.77	2.40	3.19	*1.34	0.86	2.00	2.15	1.76	2.63	2.53	2.04	3.13
Bone/soft tissue	1.71	1.44	2.03	1.81	1.22	2.59	1.38	1.07	1.80	2.08	1.64	2.65
Leukemia	3.79	3.38	4.25	*2.54	1.89	3.35	*2.79	2.33	3.35	*2.70	2.18	3.35
Lymphoma/ Hodgkin's	3.12	2.75	3.54	*1.80	1.21	2.57	2.88	2.40	3.45	3.78	3.15	4.54
Lymphoma/ non-Hodgkin's	0.60	0.43	0.80	0.45	0.20	0.89	0.63	0.41	0.91	0.80	0.53	1.17
Female genital	10.21	9.43	10.85	*1.89	1.27	2.70	#17.20	15.96	18.54	#19.26	17.76	20.88
Breast	0.36	0.24	0.53	0.29	0.10	0.69	0.28	0.14	0.48	0.33	0.17	0.60
Digestive	0.84	0.65	1.09	0.33	0.13	0.72	0.47	0.29	0.72	0.64	0.40	0.97
Other	5.65	4.95	6.46	4.93	3.56	6.66	4.82	3.97	5.87	4.76	4.07	5.58
Total	29.05	25.67	32.74	*15.38	10.44	22.17	32.60	28.33	37.75	36.88	31.94	42.87

**Includes 1979-1986.
*New Jersey rate is significantly higher.
#New Jersey rate is significantly lower.
LL: Lower limit 95 percent confidence level.
UL: Upper limit 95 percent confidence level.

of age, 15 to 19 years of age, and 20 to 24 years of age). Denominator data were derived from Bureau of the Census' *County Population Estimates (Experimental) by Age, Sex, and Race: 1980-1985.* As no comparable population estimates were available for 1979, 1980 data were used for that year. Similarly, 1985 estimates were used for Iowa for the year 1986. The population standard for all groups (direct method of standardization) was the 1980 population of the United States. The age-adjusted rates by gender, along with their respective 95 percent confidence in-

Table 3. *Age-adjusted cancer incidence rates with 95 percent confidence intervals, 0 to 24 years of age in New Jersey, 1979-1985.*

Black male cancer diagnosis	New Jersey Rate	LL	UL	Black female cancer diagnosis	New Jersey Rate	LL	UL
Brain/CNS	*1.82	1.23	2.60	Brain/CNS	1.95	1.31	2.78
Bone/soft tissue	1.87	1.26	2.68	Bone/soft tissue	1.53	0.99	2.26
Leukemia	*2.36	1.68	3.21	Leukemia	3.20	2.38	4.23
Lymphoma/ Hodgkin's	2.10	1.42	3.01	Lymphoma/ Hodgkin's	*0.88	0.48	1.47
Lymphoma/ non-Hodgkin's	1.05	0.60	1.71	Lymphoma/ non-Hodgkin's	0.31	0.10	0.73
Male genital	*0.78	0.39	1.39	Female genital	#14.11	12.24	16.24
				Breast	0.73	0.34	1.31
Digestive	1.02	0.58	1.65	Digestive	0.59	0.27	1.12
Other	*2.52	1.63	3.81	Other	3.47	2.34	4.97
Total	*13.52	8.79	20.06	Total	26.77	20.45	35.11

*New Jersey white rate is significantly higher than black rate.
#New Jersey black rate is significantly higher than white rate.
LL: Lower limit 95 percent confidence level.
UL: Upper limit 95 percent confidence level.

tervals, are found in Table 1. The age-adjusted rates for whites by gender, along with 95 percent confidence intervals for four of the five states are found in Table 2. Utah was eliminated, as the aggregate data provided did not include a racial variable. The age-adjusted rates for blacks in New Jersey are found in Table 3. New Jersey black data were compared to New Jersey white data because there were too few black cases in the comparison states for meaningful analysis. Statistically significantly different rates are those where the confidence limits do not overlap the corresponding confidence limits for New Jersey.

Age-specific rates and 95 percent confidence intervals for childhood and young adult cancer types were calculated for each of the five states based on three age groupings (0 to 4 years of age, 5 to 14 years of age, and 15 to 24 years of age) by gender and racial group. Three age groupings, rather than the five groupings used for the age-adjusted rates, allowed for larger numbers of cases in each cell, and for increased stability of rates. Selected age-specific rates are reported in the text.

RESULTS

Over the seven-year period, 11,217 new cases of cancer were registered among those 0 to 24 years of age in the five states. New Jersey, the state with the largest population, had 5,043 cases (45 percent). In all states, leukemia accounted for the largest percentage of new male cases (20 percent), followed by brain/CNS cancers (14 percent), and Hodgkin's lymphoma (13 percent). For females, the largest proportion of cancers in New Jersey, Iowa, and Connecticut were for sites in the female genital category (39, 52, and 54 percent, respectively). Utah and New Mexico listed far fewer cases of female genital cancers (7 and 13 percent, respectively).

There were 19 possible comparisons (9 for males and 10 for females) of New Jersey age-adjusted rates to those of Utah. Of these, eight rates (42 percent) were significantly higher for New Jersey residents, and no rates were significantly lower. By chance alone, we would have expected only 2.5 percent of the New Jersey rates to be higher and another 2.5 percent to be lower than those of Utah. Similarly, for comparisons with New Mexico, eight rates (42 percent) were significantly higher for New Jersey residents, and no rates were significantly lower. For comparisons with Iowa, only the rate for Hodgkin's lymphoma among males was significantly higher for New Jersey, while the New Jersey female genital rate was significantly lower. Similarly, for comparisons with Connecticut, only the rate for leukemia among males was significantly higher for New Jersey, while again the New Jersey female genital rate was significantly lower. It should be noted that two of the sites (leukemia and

Hodgkin's lymphoma) had significantly higher rates in New Jersey for 4 of 8 comparisons.

Of the 76 possible comparisons (36 for males and 40 for females), nine rates (25 percent) were significantly higher for New Jersey males than for males in other states. In no instance were New Jersey male rates significantly lower. By chance alone, we would have expected one (.9) of the New Jersey male age-adjusted rates to be higher and one age-adjusted rate (.9) to be lower than male rates for the other states. For females, nine (23 percent) of the age-adjusted rates were significantly higher for New Jersey residents than the rates for females in the comparison states, again far more than would have been expected by chance.

The age-adjusted rates for whites by gender are found in Table 2. Again, there were 19 possible comparisons (9 for males and 10 for females) for each state. For comparisons with New Mexico rates, seven rates (37 percent) were significantly higher for New Jersey residents, and no rates were significantly lower. For comparisons with Iowa, only two rates (11 percent), Hodgkin's lymphoma among males and leukemia among females, were significantly higher for New Jersey residents, while one rate (5 percent), for female genital cancers, was significantly lower. It should be noted that only one site (leukemia) had significantly higher rates in New Jersey for 4 out of 6 comparisons.

The age-adjusted rates for New Jersey blacks are found in Table 3. Within the state, white males had significantly higher incidence rates than black males for five of the nine cancer types. White females in the state had significantly higher rates than black females only for Hodgkin's lymphoma. Black females had significantly higher rates than white females for genital cancers. In general, New Jersey blacks aged 0 to 24 years had lower cancer rates than whites except for the single instance of female genital cancers.

The age-specific rate tables are too lengthy for presentation here. New Jersey rates for white males or females were significantly higher than those of New Mexico rates for 11 of 51 comparisons (22 percent). New Jersey white male or female rates were significantly higher than Iowa rates for 5 out of 51 comparisons (10 percent), and significantly lower than Iowa rates for female genital cancers. New Jersey white male or female rates were significantly higher than Connecticut rates for 1 of 51 comparisons (2 percent), and significantly lower than Connecticut rates for 1 of 51 comparisons (2 percent). Therefore, the age-specific differences with Connecticut are no greater than would be expected by chance alone.

DISCUSSION

New Jersey childhood and young adult age-adjusted cancer incidence rates were significantly higher than rates in the comparison SEER states 24 percent of the time. New Jersey rates were about the same as those of Connecticut and Iowa, and higher than those of New Mexico and Utah. Rates generally were higher among whites than blacks in the state except for female genital cancers.

The most striking finding of this research is the vastly different rates of female genital cancers reported among states. Discussions with representatives of the four comparison state registries did not elicit differences in reporting practices nor in the data provided to us. All state data managers denied the inclusion of benign and borderline cases and insisted that both in situ and malignant cases were included. The possibility remains that there are data differences that could not be identified.

Explanations for the differences in female genital cancers include ascertainment whereby some states may have more active screening programs, or screening may target younger age groups. As screening programs are designed to identify disease states while they are asymptomatic, these programs might find cases that otherwise would not be reported until the disease was manifest in later years. The possibility also exists that the incidence of female cancers significantly is higher in three of the five states. It may be that sexual activity is delayed or the number of partners is restricted due to religious and/or cultural differences among youth in New Mexico and Utah. Differences in behavior, then, might account for a true difference in disease occurrence. Additional explanations include differences in the reporting practices of physicians, hospitals, and clinics to the various registries.

The hypothesis that New Jersey is most similar to Connecticut in its pediatric and young adult cancer patterns is supported by this research. The states had statistically similar rates except for two instances—New Jersey male leukemia rates were significantly higher and female genital cancer rates were lower than those of Connecticut. In short, this research supports the hypothesis that in pediatric and young adult cancer, incidence is correlated with similarities in demographic characteristics. Based on these results, we recommend that future work compare rates of states similar in these correlates rather than simply with those for the United States as a whole. Another interesting comparison would be New Jersey's most urbanized counties—Essex, Hudson, Union, Middlesex, and Mercer—with incidence registries for SEER metropolitan-area registries.

The cancer incidence rates among New Jersey youth clarify findings from our previous work concerning childhood cancer mortality in the state.[6] Geographic, time/space clustering, and retrospective epidemiologic

studies currently are underway to look at specific cancer types found in excess. New Jersey has high numbers of high-tension wires, chemical plants, toxic waste sites, contaminated water supplies, and other environmental concerns, and there is strong public interest in exploring the associations between these possible exposures and cancers. Studies to explore some of these associations are in the planning stage. But behavioral risk factors should not be ignored. Prospective epidemiologic research on these and other factors is possible as New Jersey's pediatric and young adult population provides an adequate pool of cases from which to design and carry out future studies. ■

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Drs. Schneider and Greenberg are affiliated with the Department of Urban Studies and Community Health, Rutgers University. Dr. Donaldson is affiliated with the Department of Pediatric Hematology/Oncology, Cooper Hospital University Medical Center, Mr. Abe is affiliated with the Cancer Registry Program, New Jersey State Department of Health, and Mr. Choi is affiliated with the Department of Statistics, Rutgers University. This paper was submitted in January 1992 and accepted in June 1992. Address reprint requests to Dr. Schneider, Urban Studies and Community Health, Rutgers University, New Brunswick, NJ 08903.

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Radiology Rounds: MRI of Rotator Cuff Arthropathy

Mark T. DiMarcangelo, DO, MSc
James H. Jacoby, MD

Magnetic resonance imaging (MRI) has proved to be an excellent diagnostic tool in evaluating the musculoskeletal system. This article illustrates one particular facet of musculoskeletal MRI: investigation of the rotator cuff tendon complex.

A 62-year-old male factory worker related to his physician the onset of pain and a decreased range of motion of his shoulder. Physical examination demonstrated relative lack of range of motion, particularly abduction. Magnetic resonance imaging (MRI) of the shoulder was ordered (Figures 1 and 2).

MRI FINDINGS

Figure 1 represents a T1-weighted coronal oblique image through the rotator cuff tendon, particularly the supraspinatus tendon. Figure 2 is a T2-weighted image in a similar vicinity. Both of these images were performed in the coronal oblique plane that parallels the supraspinatus muscle. There is demonstrated increased signal on both T1- and T2-weighted images within the supraspinatus tendon, particularly in the critical zone where it attaches to the proximal humerus at the level of the greater tuberosity. This increased signal intensity is seen in association with fraying and attenuation of this tendon as well as an area of discontinuity. Also noted is fluid within the subacromial and subdeltoid bursae on the T2-weighted images, and there is evidence of hypertrophic change involving the acromioclavicular joint and acromial tip.

DISCUSSION

Figure 3 demonstrates a T1-weighted coronal oblique image through a normal shoulder. The supraspinatus tendon is homogeneous in signal intensity and is relatively hypointense when compared to surrounding musculature.[1] It is smoothly marginated and is of uniform thickness and demonstrates normal attachment to the greater tuberosity. The belly of the supraspinatus muscle demonstrates normal signal intensity without evidence of atrophy (fatty metamorphosis). There is no significant degenerative arthropathy of the acromion or acromioclavicular joint and the T2-weighted images did not disclose



Figure 1. Coronal oblique T1-weighted image of the shoulder articulation demonstrates considerable thinning of the supraspinatus tendon (straight arrow) denoting a tear. Abnormal increased signal is seen in the distal segment of the tendon (wavy arrow). In addition, notice the large horn-shaped osteophyte arising from the inferior aspect of the acromioclavicular articulation (arrowhead).



Figure 2. Coronal oblique T2-weighted image of the shoulder of the same patient illustrated in Figure 1. This scan depicts the frayed tendon more proximally (arrow) and hyperintense signal in the distal segment (curved arrow) also consistent with tear and inflammation. Fluid within the subdeltoid bursa confirms the existence of a tear within the rotator cuff tendon (arrowhead).

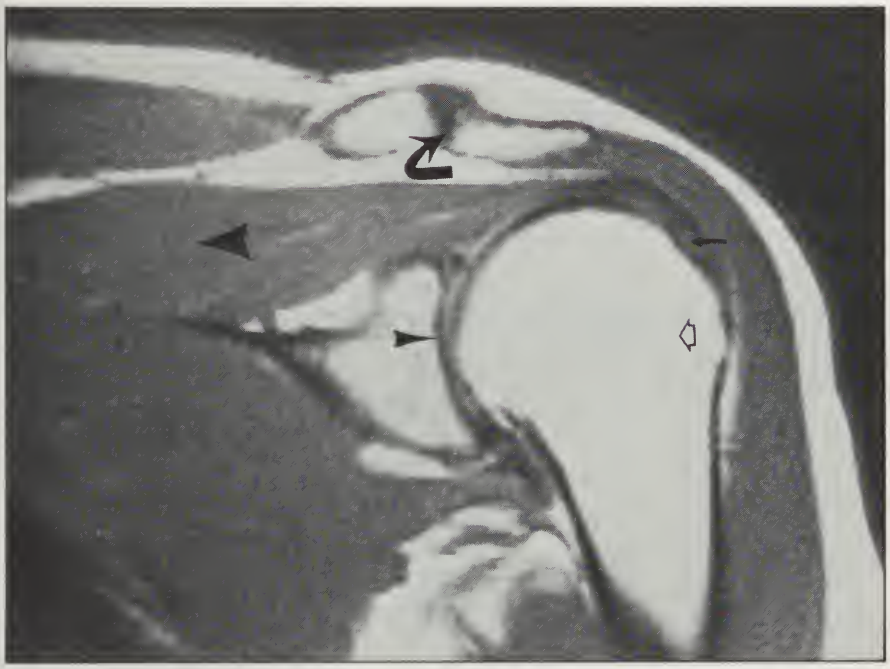


Figure 3. This is a T1-weighted image in the coronal oblique plane of a normal patient demonstrating the usual anatomic relationships. The arrow indicates the normal tendon and the clear arrow points out the marrow of the proximal humerus. The glenoid fossa is shown by the small arrowhead and the acromioclavicular joint is labelled by the curved arrow. The belly of the supraspinatus muscle is depicted by the large arrowhead.

any fluid within the subacromial or subdeltoid bursal regions. There is relative hyperintense fat within the bone marrow of the humerus and other osseous structures as well as within the subcutaneous and intramuscular fat planes.

Figures 1 and 2 demonstrate the typical findings of a tear of the rotator cuff. There is a variable spectrum of findings depicted on MRI in patients with rotator cuff tendonopathy. Patients simply may present with minimal to moderate increased signal within the rotator cuff tendon. In many instances, it is difficult to discriminate between simple tendonitis versus a partial thickness tear. Other patients may present with attenuation, fraying, and irregularity of the tendon denoting underlying tear at least on a partial thickness basis.[2] The most pronounced finding would be that in a patient who demonstrates full thickness tear with obvious discontinuity of the tendon with retraction of the proximal tendon fragment and resultant atrophy of the musculature. Atrophy on MRI is depicted as increased signal on T1-weighted images indicating the presence of fatty manifestations within the musculature.[3] Other secondary signs of rotator cuff tear include fluid in the subacromial and subdeltoid bursal compartments. Normally, fluid should not be present within these spaces since the rotator cuff tendon demarcates the superior border of the shoulder joint proper. However, when there is a tear in the rotator cuff tendon, synovial fluid then will permeate through the torn tendon into these bursal compartments.

In many instances, the pathophysiology of rotator cuff tears is based on the impingement syndrome, although this remains somewhat controversial.[1] Degenerative spurs and hypertrophic changes arising from the acromion and the acromioclavicular joint will narrow the space between the superior border of the humeral head and the acromion. This, therefore, results in impingement upon the supraspinatus tendon resulting in mechanical irritation and inflammation that eventually leads to advanced degenerative changes and may precipitate a tear. Most likely, this is the etiology depicted

on the patient described in this case report.

MRI has served as a primary diagnostic tool or important adjunctive modality along with plain film radiography and arthrography in the workup of rotator cuff tendonopathies. MRI allows for noninvasive observation of the rotator cuff musculature, tendons, and joint spaces in multiple planes. It performs this function without the employment of ionizing radiation. MRI also allows for further evaluation of osseous structures that complement plain film radiography. Arthrography only allows for detection of rotator cuff tears by demonstrating communication of the glenohumeral joint with the subacromial-subdeltoid bursae. This may result in potentially more false negative studies and MRI may be fruitful in demonstrating partial thickness tears.[2] MRI also allows for further investigation of other shoulder pathology including neoplasia and infection.

DIAGNOSIS

Full thickness tear of the supraspinatus tendon secondary to degenerative arthropathy and shoulder impingement. ■

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Dr. DiMarcangelo is attending radiologist and Dr. Jacoby is acting chief, Department of Diagnostic Radiology and Nuclear Medicine, Cooper Hospital/University Medical Center and Dr. DiMarcangelo is clinical assistant professor of radiology and Dr. Jacoby is clinical associate professor of radiology, UMDNJ-Robert Wood Johnson Medical School. The paper was submitted in May 1992 and accepted in June 1992. Address reprint requests to Dr. DiMarcangelo, Cooper Hospital, One Cooper Plaza, Camden, NJ 08103-1489.

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The Committee on Publication and the Editorial Board of *New Jersey Medicine* (names listed on page 886) would like to thank the following ad hoc reviewers and book reviewers for their contributions to the journal:

David I. Canavan, MD
Ligaya Cetano, MD
Vincent Cirillo
Barbara Irwin, MLS
James H. Jacoby, MD
Stanley R. Lane, MD
Sharan Mahal, MD
Vincent A. Maressa, JD
Vincent K. McInerney, MD
John J. Oppenheimer, MD
Robert L. Thompson, EdD
Alan H. Wolff, MD

DOCTORS' NOTEBOOK

TRUSTEES' MINUTES

A regular meeting of the MSNJ Board of Trustees was held on October 18, 1992, at the executive offices in Lawrenceville. Detailed minutes are on file with the secretary of your county society. A summary of significant actions follows:

President's Report. Heard a report on the progress of the New Jersey Health Care Reform Coalition.

Specialty Reports. Received reports from the University of Medicine and Dentistry; the New Jersey Hospital Association; and the Academy of Medicine of New Jersey.

Executive Director's Report.

1. Medicaid Physician Survey. Noted that a survey is being conducted by Medicaid for comments and perspectives of physicians regarding the program.

2. State Board of Medical Examiners (SBME). Noted the following: a revised resolution is being reviewed concerning the Physicians' Health Program; and authorized MSNJ's entry in litigation against the SBME business practice rules.

Committee on Publication. Approved the following recommendation:

That MSNJ contract with Trentypo Inc., and Fye Communications for the 1993-1994 production of *NEW JERSEY MEDICINE.*

Audit Review Committee. Approved the following resolutions:

That the audited financial statements be accepted and a copy thereof be forwarded to each component society.

That Ernst & Young be continued as the external auditors.

Unfinished Business.

1. HCFA Forms—Resolution #21. Will continue the letter writing campaign, aimed at keeping the New Jersey Congressional Delegation under pressure to resolve the HCFA claim form dilemma and will direct the AMA Delegation to reaffirm MSNJ's position (obtain permanent relief from billing on expensive and onerous HCFA claim forms) on the floor of the AMA House of Delegates in December. Also, referred to the Council on Medical Services concerns about medical claims that are illogically or irrationally rejected by insurance companies and the insurance carrier administrative appeal mechanism.

2. Annual Meeting Resolutions. Will distribute formalized copies of procedural changes for Annual Meeting resolutions at the November MSNJ Board of Trustees meeting.

3. MedAC and JEMPAC. Noted Dr. Carnes' request for contributions.

New Business. Agreed that MSNJ staff will prepare a model list of policies that physicians can adapt for use in their respective office settings that will be submitted to SBME. □

MSNJ AUXILIARY

Community public relations. Congratulations to the Gloucester County Medical Society Auxiliary (GCMSA) for the special tribute paid to their members by the Gloucester County Board of Chosen Freeholders. President Pat Schneider, President-Elect Jane Butler, and Past-President Roseann Kaplan were awarded a proclamation by the freeholders honoring GCMSA for its valuable contribution to the citizens of Gloucester County and, more specifically, to the residents of the Shady Lane Nursing Home.

Mercer County Medical Society Auxiliary sponsored a seminar, "World at Work—Understanding Occupations." The Auxiliary also made donations to Mercer County hospitals; collected clothing for Womanspace; and is gathering gift donations for Trenton Psychiatric Hospital.

Union County Medical Society Auxiliary, under the leadership of Anna Miranda, collected gift packages of cosmetics, shampoos, and colognes for the Battered

CANDIDATES FOR MSNJ OFFICES

The MSNJ Nominating Committee will meet on Wednesday, January 20, 1993, to consider candidates. The Committee will consider members other than those recommended by county medical societies and nominating delegates.

If you wish to be considered, please contact your county medical society or the Medical Society of New Jersey, 1/609/896-1766.

This is an opportunity for grassroots candidate development.

Women's Shelter in Elizabeth. They also adopted the Brother Bonaventure Extended Care Center and will provide residents with baking equipment and gardening supplies.

Warren County Medical Society Auxiliary is assisting the American Cancer Society in chairing the ten-year followup of Cancer Prevention Study 2 and President-Elect Vina Serrano has begun to train volunteers.

Sussex County Medical Society Auxiliary helped with the distribution of the "Vial of Life" in October. The Auxiliary cooperated with the County Committee on Aging and networked with retired educators.

Auxiliary members volunteered their services in organizing breast screenings in Gloucester County at Underwood Memorial Hospital and in Union County at Elizabeth General Hospital.

Fundraising. Camden County Medical Society Auxiliary (CCMSA) held a successful theater trip fundraiser to New York City to see "Crazy for You." CCMSA also held its annual art trip to attend a special Picasso exhibit at the Philadelphia Museum of Art.

Palma Formica, MD, national AMA-ERF president, kicked off the year's AMA-ERF drive with a generous $1,000 contribution. In addition, a record attendance at the November Executive Board Meeting/Holiday Boutique increased AMA-ERF funds immensely.

Burlington County Medical Society Auxiliary, under the leadership of President Trudy Reagan, held a luncheon and boutique at a Mount Laurel restaurant including a special musical video presentation featuring county and state auxiliary members.

Highlighting the theme "Alcohol and Water Sports Don't Mix," President Pat Schneider of Gloucester County, reported that her county provided funding for the ROW/"Alcohol and Water Sports Don't Mix" project through donations and fundraisers, including a fashion show and Chinese auction.

Monmouth County Medical Society Auxiliary President Susan Kahn headed a team of volunteer Auxiliary members who participated in "Enforcement and Beyond" sponsored by the New Jersey Coalition for Impaired Driving held at the Ocean Place Hilton. The Auxiliary sponsored a booth with the theme: "Alcohol and Water Sports Don't Mix." They used the now famous "ROW boat" as a backdrop for the new educational posters stickers, and buttons they distributed to the high school students.

Peg Reichwein, president of

DAILY SCHEDULE
1993 MSNJ ANNUAL MEETING

SATURDAY, MAY 1, 1993

3:30 P.M. Board of Trustees Meeting
7:00 P.M. Officers' Reception/Dinner (by invitation only)

SUNDAY, MAY 2, 1993

8:00 A.M. Registration Opens
8:00 A.M. Meeting—AMA Delegation
9:30 A.M. Message Center Opens
10:00 A.M. Educational Program
11:30 A.M. Exhibits Open
12:15 P.M. Academy Lecture
2:00 P.M. House of Delegates
3:30 P.M. Reference Committee Meetings

MONDAY, MAY 3, 1993

7:30 A.M. Breakfast Meeting
8:00 A.M. Registration Opens
8:00 A.M. Message Center Opens
9:00 A.M. House of Delegates (Election)
12:15 P.M. Luncheon "Women in Medicine"
12:30 P.M. Golden Merit Award Ceremony and Reception
2:30 P.M. Reference Committee Meetings
5:00 P.M. JEMPAC Political Forum
5:45 P.M. JEMPAC Wine and Cheese Reception
7:00 P.M. Mercer County Medical Society Reception Honoring William E. Ryan, MD, President

TUESDAY, MAY 4, 1993

8:00 A.M. Registration Opens
8:00 A.M. Message Center Opens
8:30 A.M. Exhibits Open
9:00 A.M. House of Delegates
2:00 P.M. Exhibits Close
6:00 P.M. Inaugural Ceremony
7:00 P.M. Inaugural Reception and Dinner Honoring Joseph N. Micale, MD, Incoming President

WEDNESDAY, MAY 5, 1993

8:00 A.M. Registration Opens
8:00 A.M. Message Center Opens
9:00 A.M. Educational Program
1:00 P.M. Board of Trustees Meeting

HOUSING APPLICATION

227th ANNUAL MEETING
MEDICAL SOCIETY OF NEW JERSEY

May 2 to May 5, 1993

TRUMP TAJ MAHAL CASINO/RESORT
1000 BOARDWALK AT VIRGINIA AVENUE, ATLANTIC CITY, NJ 08401
RESERVATION DEPARTMENT 1/800/825-8786

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City _____ State _____ Zip _____

Home Phone _____ Business Phone _____

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Date of Departure _____ Time _____

A one-night deposit (equivalent to room rate) is required with all reservation requests. Please send check or money order payable to **TRUMP TAJ MAHAL CASINO/RESORT** or complete the following:

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SCHEDULE OF RATES SUBJECT TO 12% TAX

☐ SINGLE **$115** ☐ DOUBLE **$115** ☐ Extra Person **$25**

(Reservations must be received prior to April 2, 1993)

☐ One Bedroom Suite **$275 per day**

☐ One Bedroom Hospitality Suite **$300 per day**

Check-out time is 12 NOON. Rooms may not be available for check-in until after 4 P.M. Check-in time on Sundays is 6 P.M. FORTY-EIGHT (48) HOURS NOTICE OF CANCELLATION is required for a full refund. PARKING: FREE PARKING TO REGISTERED GUESTS. One car per room.

☐ Check if Official Delegate County _____

PLEASE NOTE: Effective March 1, 1992, Atlantic City casino hotels must levy a $2 per room, per night hotel room use as legislated by the state of New Jersey.

The proceeds from the fees collected pursuant to this legislation shall be paid into a special fund that will be established and held by the Atlantic City Convention Center Authority. Amounts in the special fund shall be expended by the Convention Center Authority solely for the purposes of promoting tourism, conventions, resorts, and casino gaming.

★★★

Salem County Medical Society Auxiliary, is directing the distribution of the new promotional ROW materials to schools, offices, and businesses in Salem and Cumberland Counties.

Warren County Medical Society Auxiliary also has been busy distributing ROW posters and buttons throughout the county and even in Pennsylvania.

State activities. The Auxiliary, under the chairmanship of Rosi Bohn Rivas, sponsored a poster contest for physicians' children and the children of office personnel in conjunction with the MSNJ program "Clearing the Air: Addressing Nicotine Dependence in the 1990s."

MSNJ and the Auxiliary cosponsored free eye health screenings at approximately 100 locations across the state in September.

Membership Drive. There is a major drive to recruit members for the one and only organization devoted solely to working for organized medicine. Nationwide, the Auxiliary is composed of 65,000 physicians' spouses dedicated to improving the health and welfare of citizens through health-related projects and lobbying efforts for sound medical legislation. Physicians are urged to sponsor their spouses as active or supporting members of the Auxiliary. National, state, and county dues average $55 and the benefits are unlimited.

Essex County Medical Society Auxiliary, at a get-together at President Nella Lima's home, recruited six new members.

President Gretchen Sorensen of the Cape May Medical Society Auxiliary is recruiting new members by inviting "new faces" to dinner meetings with speakers.

Lauren Eder, president of Mercer County Medical Society Auxiliary had a pot luck international luncheon featuring a speaker on travel, and a Holiday Luncheon at the Nassau Inn in Princeton, featuring a speaker on fitness. A Valentine's Tea is set for February with speaker Irene Gersten, PhD, scheduled to talk on "Women in Literature."

Monmouth County Medical Society Auxiliary (MCMSA) members planned "I Love My Doctor" picnic and softball game to benefit the American Red Cross Hurricane Relief Fund. MCMSA also sponsored a trip to New York City to the Museum of Modern Art to see "Henri Matisse: A Retrospective." Luncheon and shopping were part of the schedule.

President Louisa Johnson and the Sussex County Medical Society Auxiliary recently held a wonderful "Coffee in the Country" in a recently restored home called Northrop House—a 1770 masterpiece. New and prospective members were included.

President Peggy Luancing of Warren County Medical Society Auxiliary rounded up prospective new members for a "hot doggity" barbeque and swim party. □
Marion H. Geib, President

UMDNJ NOTES

UMDNJ walkathon. The Third UMDNJ "Walk of Champions" raised $160,000 for University programs that serve women and children living with AIDS. More than 1,600 northern, central, and southern New Jersey health care professionals, community leaders, AIDS patients, and the public participated in the walkathon, held in Branch Brook Park, Newark, and Main Street, Voorhees. Governor Florio was honorary walkathon chairman.

UMDNJ-Eagleton Poll: Tax cigarettes and alcohol. Seven out of 10 New Jersey residents favor increasing taxes on cigarettes and alcoholic beverages to pay for the hospital bills of the poor and uninsured, according to the latest UMDNJ-Eagleton Institute poll. Almost the same majority—73 percent—of the 800 adults polled said that all health insurance companies in New Jersey should be required to cover all applicants. Seventeen percent said that the current system, which allows some companies to reject individuals with serious health problems, should be maintained.

Dramatic rise in TB in HIV-infected children. At a national conference of infectious disease specialists, researchers at UMDNJ-New Jersey Medical School, Newark, reported a significantly increased incidence of tuberculosis (TB) in HIV-infected children in Newark. Of 12 cases of HIV-infected children with TB, eight children were diagnosed in the past two years.

ARE YOU MOVING?

If so, please send a change of address to *NEW JERSEY MEDICINE*, Medical Society of New Jersey, Two Princess Road, Lawrenceville, NJ 08648, at least six weeks before you move.

Name _____

Old Address _____

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City _____ State _____ Zip _____

No cases of TB had been diagnosed in HIV-infected children between 1980 and 1987.

While the number of cases is still small, the fact that 67 percent of one group was diagnosed in the past two years indicates that TB is an escalating public health problem for HIV-infected children.

Drugs for treating impotence. Two new drugs that may advance treatment for men who are experiencing impotence are being tested at UMDNJ-Robert Wood Johnson Medical School. Researchers hope these drugs—fluparoxan and prostaglandin—will be more effective and have fewer side effects than drugs currently on the market.

Fluparoxan is a drug taken orally to stimulate sexual drive and erection. It appears to be most effective in men who have recently developed an erectile disorder or who experience the problem sporadically.

Prostaglandin is a synthetic hormone that, when injected into the base of the penis, aids erectile function in men whose impotence is caused by a medical condition such as diabetes or heart disease.

Investigators test bitter pill. Researchers have a "bitter pill" for smokers who want to quit the habit—a lozenge that produces a bad taste when a smoker lights up. The investigators are seeking 500 volunteers for the two-year study that will test the effectiveness of anti-smoking counseling, coupled with the newly patented lozenge. Cherry tasting at the start, the lozenge becomes unpleasant when it mixes with the components of cigarette smoke. The study is part of a comprehensive smoking cessation program at UMDNJ-New Jersey Medical School. Dr. Norman Hymowitz, professor of clinical psychiatry, is directing the study. ☐ Stanley S. Bergen, Jr, MD, President

PLACEMENT FILE

The following physicians have written to the executive offices of MSNJ seeking information on opportunities for practice in New Jersey. If you are interested in any further information concerning these physicians, we suggest you make inquiries directly to them.

Allergy

Tarun J. Shah, MD, 39C Village of Stoney Run, Maple Shade, NJ 08052. Also, pediatrics. Baroda (India) 1984. Board eligible. Board certified (PED). Solo, partnership, group.

Emergency Medicine

Jayen Shah, MD, P.O. Box 251, Bordentown, NJ 08505. Baroda Medical College 1991. Board certified. Available.

Gastroenterology

Steven Nadler, MD, Robert Wood Johnson University Hospital, MEB 478, GI Division, New Brunswick, NJ 08901. UMDNJ 1987. Board eligible. Board certified (IM). Group, partnership, solo. Available July 1993.

Internal Medicine

Gregory E. Broslawski, DO, 57 Westchester Terr., Annandale, NJ 08801. UMDNJ 1989. Board eligible. Available July 1993.

Nephrology

Vinitha Raghavan, MD, 7 Overbrook Rd., Upper Saddle River, NJ 07458. Guntur Medical College (India) 1981. Board certified (IM). Group or partnership. Available January 1993.

Occupational/Environmental Medicine

Jan Lieben, MD, 2200 Ben Franklin Parkway, #905 South, Philadelphia, PA 19130. Liverpool 1943. Board certified. Part time, 30 hours/week.

Oncology

Barry M. Yafe, MD, 107 Forest St., Providence, RI 02906. New York University 1984. Board certified (ONCOL and IM). Group or partnership. Available.

Surgery

Mark A. Bartolozzi, MD, Westchester County Medical Center, P.O. Box 17, Valhalla, NY 10595. New York Medical College 1987. Board eligible. Partnership. Available.

Jayen C. Shah, MD, P.O. Box 251, Bordentown, NJ 08505. Baroda Medical College 1976. Also, emergency medicine. Board eligible. Hospital based or office. Available.

1993 MSNJ ANNUAL MEETING

May 2, 1993-May 5, 1993

Taj Mahal Casino/Resort
Atlantic City, NJ

Application appears on page 948.

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CONTINUING EDUCATION

ANESTHESIOLOGY

January

15 **Nonoperative Management of Back Pain**
8:30-9:30 A.M.—United Hospitals Medical Center, Newark
(AMNJ)

19 **Anesthesiology Meeting**
All day—Ramada Inn, Clark
(NJ State Society of Anesthesiologists)

DERMATOLOGY

January

20 **Robert Wood Johnson Medical School Dermatological Conference**
6-9 P.M.—Rutgers Community Health Plan, 57 U.S. Highway 1, South, New Brunswick
(UMDNJ, Division of Dermatology)

February

9 **General Membership Meeting**
6 P.M.—Schering Corporation, Kenilworth
(Dermatological Society of NJ)

17 **Robert Wood Johnson Medical School Dermatological Conference**
6-9 P.M.—Rutgers Community Health Plan, 57 U.S. Highway 1, South, New Brunswick
(UMDNJ, Division of Dermatology)

DIABETES

January

13 **Diabetes-Related Cardiovascular Disease**
12:30-1:30 P.M.—Kessler Institute for Rehabilitation, West Orange
(AMNJ and NJDOH)

13 **Diabetic Retinopathy**
1-2 P.M.—VA Medical Center, Lyons
(AMNJ and NJDOH)

13 **Diabetic Retinopathy**
8-9 A.M.—Somerset Medical Center, Somerville
(AMNJ)

February

3 **Diabetes in Pregnancy**
12 NOON-1 P.M.—Southern Ocean County Hospital, Manahawkin
(AMNJ and NJDOH)

11 **Prevention of Lower Extremity Amputations**
12:30-1:30 P.M.—The Mountainside Hospital, Montclair
(AMNJ)

24 **Diabetes-Related Cardiovascular Disease**
12 NOON-1 P.M.—Southern Ocean County Hospital, Manahawkin
(AMNJ and NJDOH)

INFECTIOUS DISEASE

January

5 **Chronic Epstein-Barr Virus**
12 NOON-1 P.M.—The Hospital Center at Orange, Orange
(AMNJ and NJDOH)

6 **Identification and Management of Asymptomatic HIV Infection**
9-10 A.M.—Elizabeth General Medical Center, Elizabeth
(NJDOH and AMNJ)

7 **Diagnosis and Treatment of AIDS**
10-11 A.M.—Hunterdon Developmental Center, Clinton
(AMNJ and NJDOH)

11 **Identification and Management of Asymptomatic HIV Infection**
1-2 P.M.—New Lisbon Developmental Center
(NJDOH and AMNJ)

11 **Integrating TB Management into Care of the HIV-Infected Patient**
3-4 P.M.—MCOSS Nursing Services, Red Bank
(AMNJ and NJDOH)

13 **Identification and Management of Asymptomatic HIV Infection**
8-9 A.M.—Children's Specialized Hospital, Mountainside
(NJDOH and AMNJ)

13 **Identification and Management of Asymptomatic HIV Infection**
11 A.M.-12 NOON—Kessler Memorial Hospital, Hammonton
(NJDOH and AMNJ)

13 **Integrating TB Management into Care of the HIV-Infected Patient**
11 A.M.-12 NOON—West Hudson Hospital, Kearny
(AMNJ and NJDOH)

18 **Identification and Management of the HIV-Indeterminant Infant**
12 NOON-1 P.M.—Community Medical Center, Toms River
(AMNJ and NJDOH)

19 **Infection Control in the HIV Era**
1:30-2:30 P.M.—Kimball Medical Center, Lakewood
(AMNJ)

26 **Diagnosis and Treatment of AIDS**
12 NOON-1 P.M.—West Jersey Hospital, Voorhees
(AMNJ and NJDOH)

February

1 **Identification and Management of Asymptomatic**

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Moderator: Michael S. Feldman, M.D.

3:00-5:00 Patients with interesting heart sounds and murmurs will be presented to the audience. Pertinent chest x-rays will also be demonstrated. The role of clinical observation, palpation and cardiac auscultation in diagnosing various cardiac conditions will be emphasized. Stethophones will be available at each seat.

Case Presentations—***Harry G. Zegel, M.D., Jeffrey G. Kegel, M.D.***
Panel Discussion—***Robert I. Katz, M.D., Howard Rosner, D.O., Bernard L. Segal, M.D.***

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The Philadelphia Heart Institute at Presbyterian Medical Center is an affiliate of the University of Pennsylvania.

**Presbyterian Medical Center designates this continued medical education activity for 2 credit hours in Category I of the Physicians' Recognition Award of the American Medical Association and the Pennsylvania Medical Society Membership requirement. Nine sessions, 18 credits.*

HIV Infection
11:30 A.M.-12:30 P.M.—Columbus Hospital, Newark
(AMNJ and NJDOH)

3 **Identification and Management of Asymptomatic HIV Infection**
11:30 A.M.-12:30 P.M.—Hamilton Hospital, Trenton
(AMNJ and NJDOH)

8 **Infection Control in Private Office Settings**
7-8 P.M.—Wallkill Valley General Hospital, Sussex
(AMNJ and NJDOH)

8 **Infection Control in the HIV Era**
11:30 A.M.-12:30 P.M.—Columbus Hospital, Newark
(AMNJ)

10 **Identification and Management of Asymptomatic HIV Infection**
8-9 A.M.—Somerset Medical Center, Somerville
(AMNJ and NJDOH)

17 **Identification and Management of Asymptomatic HIV Infection**
9-10 A.M.—Warren Hospital, Phillipsburg
(NJDOH and AMNJ)

17 **Identification and Management of Asymptomatic HIV Infection**
9-10 A.M.—Runnells Specialized Hospital, Berkeley Heights
(AMNJ and NJDOH)

18 **Identification and Management of Asymptomatic HIV Infection**
1:30-2:30 P.M.—Essex County Hospital Center, Cedar Grove
(AMNJ and NJDOH)

22 **Integrating TB Management into Care of the HIV-Infected Patient**
1:30-2:30 P.M.—Kimball Medical Center, Lakewood
(AMNJ and NJDOH)

23 **Infection Control in the HIV Era**
2-3 P.M.—New Jersey Veterans Home, Paramus
(AMNJ)

24 **Infection Control in the HIV Era**
1:30-2:30 P.M.—Essex County Hospital Center, Cedar Grove
(AMNJ and NJDOH)

MEDICINE

January

5 **Chronic Epstein-Barr Virus**
12 NOON-1 P.M.—The Hospital Center at Orange, Orange
(AMNJ)

6 **Endocrinology Meeting**
6 P.M.—Holiday Inn, Newark Airport
(AMNJ)

6 **Endocrinology Grand Rounds**
11:30 A.M.-12:45 P.M.—VA Medical Center, East Orange
(AMNJ)

6 **Endocrinology Conference**
4-5 P.M.—University Hospital, Newark
(AMNJ)

7 **Occupational Asthma in New Jersey**
8-9 A.M.—Somerset Medical Center, Somerville
(AMNJ)

7 **Medical Grand Rounds**
9:30-10:30 A.M.—Newark Beth Israel Medical Center, Newark
(AMNJ)

8 **Smoking Cessation**
10:30-11:30 A.M.—Marlboro Psychiatric Hospital
(AMNJ)

11 **Medical Problems in the Elderly**
11:30 A.M.-12:30 P.M.—Columbus Hospital, Newark
(AMNJ)

13 **Diabetic Retinopathy**
8-9 A.M.—Somerset Medical Center, Somerville
(AMNJ)

13 **Endocrinology Grand Rounds**
11:30 A.M.-1 P.M.—VA Medical Center, East Orange
(AMNJ)

13 **Interhospital Endocrine Rounds**
3:30-5 P.M.—Rotating hospitals in Newark and East Orange
(AMNJ)

15 **Nonoperative Management of Back Pain**
8:30-9:30 A.M.—United Hospitals Medical Center, Newark
(AMNJ)

15-16 **American College of Physicians Meeting**
Sheraton Woodbridge Hotel, Woodbridge
(AMNJ)

15-17 **Winter Ski Weekend**
Great Gorge
(NJ Academy of Family Physicians)

19 **Insights into Protein Wasting in Uremia**
6 P.M.—Overlook Hospital, Summit
(Nephrology Society of NJ)

20 **Endocrinology Grand Rounds**
11:30 A.M.-1 P.M.—VA Medical Center, East Orange
(AMNJ)

21 **Update on Risks of Smoking**
5-6 P.M.—Somerset Medical Center, Somerville
(Somerset Medical Center)

22 **Applied Psychotherapy for Office Practice**
10:30-11:30 A.M.—Marlboro Psychiatric Hospital
(AMNJ)

26 **Medical Problems in the Elderly**
2-3 P.M.—New Jersey Veterans Home, Paramus
(AMNJ and NJDOH)

27 **Medical Problems in the Elderly**
12 NOON-1 P.M.—Southern Ocean County Hospital, Manahawkin
(AMNJ)

27 **Endocrinology Grand Rounds**
11:30 A.M.-1 P.M.—VA Medical Center, East Orange
(AMNJ)

27 **Interhospital Endocrine Rounds**
3:30-5 P.M.—Rotating hospitals in Newark and East Orange
(AMNJ)

28 **Keeping Love Alive**
6:30-7:30 P.M.—UMDNJ-Robert Wood Johnson University Hospital, New Brunswick
(AMNJ)

28 **Advances in Renal and Obstetrical Embolotherapy**
4-5 P.M.—New Jersey Medical School, Newark
(AMNJ)

February

1 **Medical Aspects of Behavior Management**
1-2 P.M.—New Lisbon Developmental Center, New Lisbon
(AMNJ)

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Department of Medicine Grand Rounds

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For more information, contact the Office of Continuing Education at 215-762-8263.

JANUARY 1993

JANUARY 6th
Lupis Nephritis: Clinical Course and Therapy - 1993
Gerald B. Appel, M.D.
Professor of Clinical Medicine, Director, Clinical Nephrology, Columbia-Presbyterian Medical Center, New York, NY

JANUARY 13th
Experimental Mitral Regurgitation: The Hearth and Sarcomere
James F. Spann, M.D.
Professor of Medicine, Director, Division of Cardiology, Director, Gazes Cardiac Research Institute, Medical University of South Carolina, Charleston

The Adrenergic Nervous System in Heart Failure
Michael R. Bristown, M.D., Ph.D.
Professor of Medicine, Head, Division of Cardiology, University of Colorado Health Center, Denver

JANUARY 20th
Hypercoagulation
S. Benham Kahn, M.D.
Professor and Vice Chair of Neoplastic Diseases, Hahnemann University

JANUARY 27th
Metabolism of Alcohol and Associated Hepatic and Metabolic Disorders
Charles Lieber, M.D.
Professor of Medicine & Pathology, Mount Sinai School of Medicine, Director, GI-Liver Training Program and Alcohol Research & Treatment Center, Bronx, VA Medical Center, Bronx, NY

FEBRUARY 1993

FEBRUARY 3rd
Parkinsons: Pitfalls of Treatment
Norman Leopold, D.O.
Clinical Associate Professor of Neurology, Hahnemann University

David Roeltgen, M.D.
Associate Professor of Neurology, Hahnemann University

Jay S. Schneider, Ph.D.
Associate Professor of Neurology, Hahnemann University

FEBRUARY 10th
Hypercholesterolemia: A Second Opinion
Sylvan L. Weinberg, M.D.
Clinical Professor of Medicine, Wright State University School of Medicine, Chairman of Cardiology, Good Samaritan Hospital, Dayton

FEBRUARY 17th
Treatment of Human Immunodeficiency Virus Infection
Martin Hirsch, M.D.
Professor of Medicine, Harvard Medical School, Infectious Diseases Unit, Massachusetts General Hospital, Boston

FEBRUARY 24th
Legionella
Victor Yu, M.D.
Professor of Medicine, University of Pittsburgh School of Medicine
Chief, Infectious Diseases Section, VA Medical Center, Pittsburgh

MARCH 1993

MARCH 3rd
Critical Reading of the Medical Literature
Robert H. Fletcher, M.D.
Editor, Annals of Internal Medicine, Philadelphia

MARCH 10th
Vesicular Billous Disorders
Richard L. Spielvogel, M.D.
Professor and Acting Chair, Department of Medicine, Director, Division of Dermatology, Hahnemann University

MARCH 17th
Clinical Pathological Case Presentation
Brad B. Moore, M.D.
Sunil Natrajan, M.D.
Savas Petrides, M.D.
W. Clay Warnick, M.D.
Chief Medical Residents, Hahnemann University

MARCH 24th
Skeletal Changes in Spaceflight
Sara Bond Amaud, M.D.
Research Scientist, Life Science Division, University of California/San Francisco

MARCH 31st
Acute Myocardial Infarction in the '90s
J. Ward Kennedy, M.D.
Professor of Medicine, Director, Division of Cardiology, University of Washington School of Medicine, Seattle

Wednesday Medical Seminar Series

8:30 a.m. to 3:30 p.m.

JANUARY 13, 1993
Mechanisms and Treatment of Congestive Heart Failure
James F. Spann, M.D.
Michael R. Bristow, M.D., Ph.D.

FEBRUARY 17, 1993
Treatment of HIV and HIV-Related Opportunistic Infections
John G. Bartlett, M.D., Martin Hirsch, M.D.
Rob Roy MacGregor, Peter Selwyn, M.D.

MARCH 10, 1993
Dermatology
Richard Spielvogel, M.D.

Seminar Director: Allan B. Schwartz, M.D., Professor and Vice Chair of Medicine, Director, Continuing Medical Education for the Department of Medicine

Conflict of Interest Statement: All faculty participating in continuing medical education programs sponsored by Hahnemann University are expected to disclose to the audience any real or apparent conflict(s) of interest related to the content of their presentation.

Statement of Accreditation: As an organization accredited by the Accreditation Council for Continuing Medical Education (ACCME), Hahnemann University designates this continuing medical education activity as Category 1 of the Physician's Recognition Award of the American Medical Association. One credit hour may be claimed for each hour of participation by the individual physician.

3 **Medical Problems in the Elderly**
9-10 A.M.—Warren Hospital, Phillipsburg
(AMNJ and NJDOH)

3 **Medical Problems in the Elderly**
9-10 A.M.—Elizabeth General Medical Center, Elizabeth
(AMNJ and NJDOH)

3 **Endocrinology Grand Rounds**
11:30 A.M.-1 P.M.—VA Medical Center, East Orange
(AMNJ)

3 **Interhospital Endocrine Rounds**
3:30-5 P.M.—Rotating hospitals in Newark and East Orange
(AMNJ)

10 **Endocrinology Grand Rounds**
11:30 A.M.-1 P.M.—VA Medical Center, East Orange
(AMNJ)

10 **Interhospital Endocrine Rounds**
3:30-5 P.M.—Rotating hospitals in Newark and East Orange
(AMNJ)

16 **Cardiac Disease in the Renal Failure Patient**
Overlook Hospital, Summit
(Nephrology Society of NJ)

17 **Endocrinology Grand Rounds**
11:30 A.M.-1 P.M.—VA Medical Center, East Orange
(AMNJ)

17 **Interhospital Endocrine Rounds**
3:30-5 P.M.—Rotating hospitals in Newark and East Orange
(AMNJ)

18-19 **Quality Management for the Medical Professional**
8:30 A.M.-5:30 P.M.—Forrestal Village, Princeton
(Philip Crosby Associates, Inc.)

18 **Clinical Significance of Circadian Variation in Coronary Artery Disease**
5-6 P.M.—Somerset Medical Center, Somerville
(Somerset Medical Center)

18 **Renal Sinuses: Imaging, Curios and Caveats**
4-5 P.M.—New Jersey Medical School, Newark
(UMDNJ)

19 **Management of Abdominal Emergencies**
10:30-11:30 A.M.—Marlboro Psychiatric Hospital, Marlboro
(AMNJ)

24 **Endocrinology Grand Rounds**
11:30 A.M.-1 P.M.—VA Medical Center, East Orange
(AMNJ)

24 **Interhospital Endocrine Rounds**
3:30-5 P.M.—Rotating hospitals in Newark and East Orange
(AMNJ)

25-28 **Orthotics: A Comprehensive Course**
All day—Kessler Conference Center, West Orange
(Kessler Institute for Rehabilitation)

26 **Advances in Antibiotic Therapy**
10:45-11:45 A.M.—Greystone Park Psychiatric Hospital, Greystone Park
(AMNJ)

ONCOLOGY AND RADIATION ONCOLOGY

January

27 **Scientific Meeting**
6:30-9:30 P.M.—The Manor, West Orange
(Radiation Oncology Section, AMNJ)

February

2 **Breast Cancer**
12 NOON-1 P.M.—The Hospital Center at Orange, Orange
(AMNJ)

25 **Scientific Meeting**
6:30-9:30 P.M.—The Manor, West Orange
(Head and Neck Oncology Section, AMNJ)

RADIOLOGY

21 **Scientific Meeting**
7:30-10 P.M.—Saint Barnabas Medical Center, Livingston
(Radiological Society of NJ and Diagnostic Radiology Section)

28 **Visiting Professor Lecture**
1:30-5 P.M.—Saint Barnabas Medical Center, Livingston
(Department of Radiology)

February

18 **Radiology of the Bladder**
7:30-10 P.M.—Saint Barnabas Medical Center, Livingston
(Radiological Society of NJ and AMNJ)

25 **Visiting Professor Lecture**
1:30-5 P.M.—Saint Barnabas Medical Center, Livingston
(Department of Radiology)

MEETINGS OF THE BOARD OF TRUSTEES

of the Medical Society of New Jersey

December 20, 1992
January 17, 1993
February 21, 1993
March 21, 1993

Meetings of the Board of Trustees are open to all physicians.
For further information, call MSNJ headquarters, 1/609/896-1766.

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A Medical Seminar

Mechanisms and Treatment of CONGESTIVE HEART FAILURE

CLINICAL ADVANCES CONFERENCE

Tuesday, January 12, 1993
4 - 6 p.m.

MEDICAL SEMINAR

Wednesday
January 13, 1993
8:30 a.m. - 3:30 p.m.

For further information, please call 215-762-8263.

Hahnemann University

Heart Failure/ Cardiac Transplant Center

This program was developed by the Department of Medicine as part of their Continuing Medical Education Seminar Series in conjunction with the...

Heart Failure/Cardiac Transplant Center

LEARNING OBJECTIVES:
This seminar will provide the participant with a comprehensive review of the current theories regarding mechanisms of heart failure as well as an in-depth discussion of present and future therapeutic options for the heart failure patient. Actual case studies will be presented to illustrate selected concepts of patient management.

THE PARTICIPANT WILL:
- become familiar with the pathogenetic mechanisms of heart failure;
- describe the long-term peripheral vascular changes in chronic heart failure;
- discuss and compare the results of recent large clinical trials of vasodilator therapy in heart failure;
- recognize the mechanisms of heart failure in progressive valvular heart disease;
- identify patients who are suitable candidates for heart transplantation.

GUEST FACULTY

Michael R. Bristow, M.D., Ph.D.
Professor of Medicine, Head, Division of Cardiology, University of Colorado Health Sciences Center, Denver, CO

James F. Spann, M.D.
Professor of Medicine, Director, Cardiology Division, Director, Gazes Cardiac Research Institute, Medical University of South Carolina, Charleston, SC

HAHNEMANN FACULTY
Recognized experts from Hahnemann University will participate in clinical case presentations and discussions.

Marc Cohen, M.D.*
Susan Brozena, M.D.*
Judy Blake-Shilling, R.N.
Leonard S. Dreifus, M.D.
Mark Fiengo, D.O.
Jane Fitzpatrick, M.D.
Arnold K. Gash, M.D.
Deborah Morley, Ph.D.
Richard L. Spielvogel, M.D.
** Course Co-directors*

CONFLICT OF INTEREST STATEMENT:
All faculty participating in continuing medical education programs sponsored by Hahnemann University are expected to disclose to the audience any real or apparent conflict(s) of interest related to the content of their presentations.

ACCREDITATION:
AMA - Hahnemann University is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to sponsor continuing medical education for physicians. Hahnemann University designates each hour of attendance at Tuesday's and Wednesday's activities for one credit hour of Category 1 of the Physician's Recognition Award of the American Medical Association for a maximum of eight credit hours.

LOCATION:
Classroom C (Alumni Hall) is located on the second floor of the New College Building, 15th and Vine Streets. Entrance is off of 15th Street, just south of Vine Street. Discount parking available at the Philadelphia Gateway Garage, 15th and Spring Streets.

This program has been partially funded through an educational grant from Merck Sharp and Dohme Pharmaceutical Company.

IN MEMORIAM

LLOYD J. BRONSON

A member of our Mercer County component, Lloyd Jay Bronson, MD, passed away on June 28, 1992. Dr. Bronson was born in New York City in 1944. He was awarded a medical degree from Boston University School of Medicine, Massachusetts, in 1968. He completed a fellowship at Mt. Sinai Hospital, New York, in 1970. Dr. Bronson served an internship at Los Angeles County-U.S.C. Medical Center and a residency at Beth Israel Medical Center and at Manhattan Eye and Ear Hospital, both in New York. Dr. Bronson was an ophthalmologist and practiced in Princeton and Cranbury. He was an attending at The Medical Center at Princeton. Dr. Bronson was a diplomate of the American Board of Ophthalmology.

KALMAN CHASE

Eighty-four-year-old Kalman Chase, MD, of Sarasota, Florida, passed away on July 11, 1992. He was born in New York City on November 3, 1908. Dr. Chase earned a medical degree from the State University of Syracuse, New York, in 1934. The following year, he received his license to practice medicine in New Jersey. Dr. Chase practiced in Ho-Ho-Kus for many years and was on staff at Valley Hospital, Ridgewood, and at Bergen Pines County Hospital, Paramus. Dr. Chase specialized in cardiology. He was past-president of the Bergen County chapter of the American Heart Association, and a member of our Bergen County component and of the American Medical Association. Dr. Chase resided in Ho-Ho-Kus before retiring to Florida.

DANIEL S. CIERI

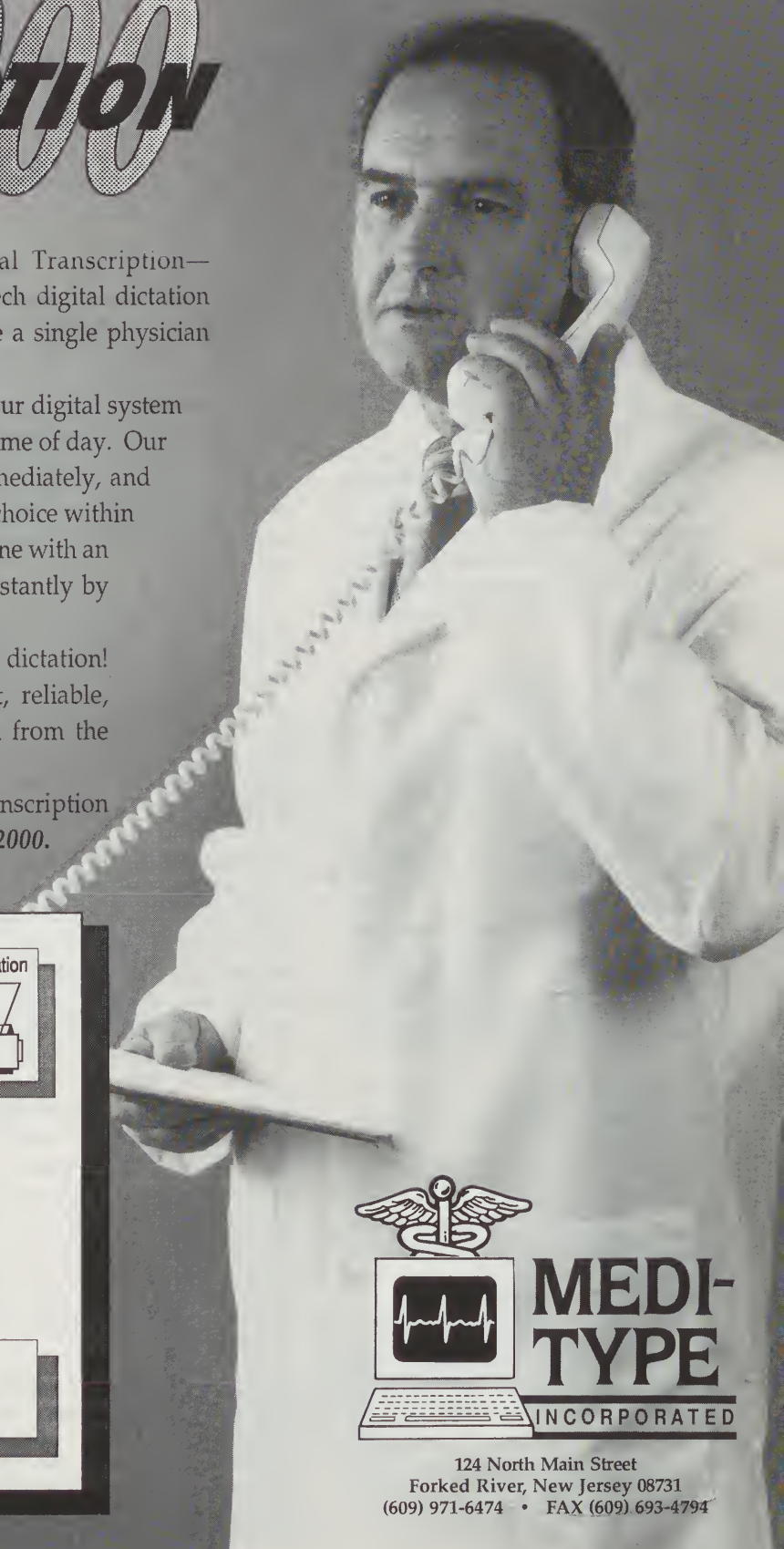
Born on October 4, 1907, in New York City, Union City resident Daniel Salvatore Cieri, MD, died on July 28, 1992. Dr. Cieri was awarded a medical degree from Bellevue Hospital Medical College, New York, in 1932. The following year he received his New Jersey medical license. Dr. Cieri was a general practitioner in Union City. During his lengthy medical career, he was a physician for the Union City school system for 35 years. He was affiliated with North Hudson Hospital, Weehawken, and was a member of our Hudson County component, of the American Medical Association, and of the North Hudson Physicians Society. Dr. Cieri was a World War II veteran.

LEWIS W. GRAY

On July 19, 1992, Lewis William Gray, MD, passed away at the age of 45. Dr. Gray was born in Newark on January 8, 1947. He graduated from Jefferson Medical College, Philadelphia, in 1973. Dr. Gray completed an internship at Boston City Hospital, Massachusetts, in 1974; a residency at Framingham Union Hospital, Massachusetts, in 1975 and at Jefferson University Hospital, Philadelphia, in 1976; and a fellowship at Jefferson University Hospital in 1978. A cardiologist, Dr. Gray was an attending at Newton Hospital. He was a member of our Sussex County component, a fellow of the American College of Cardiology, and a diplomate of the American Board of Cardiovascular Disease.

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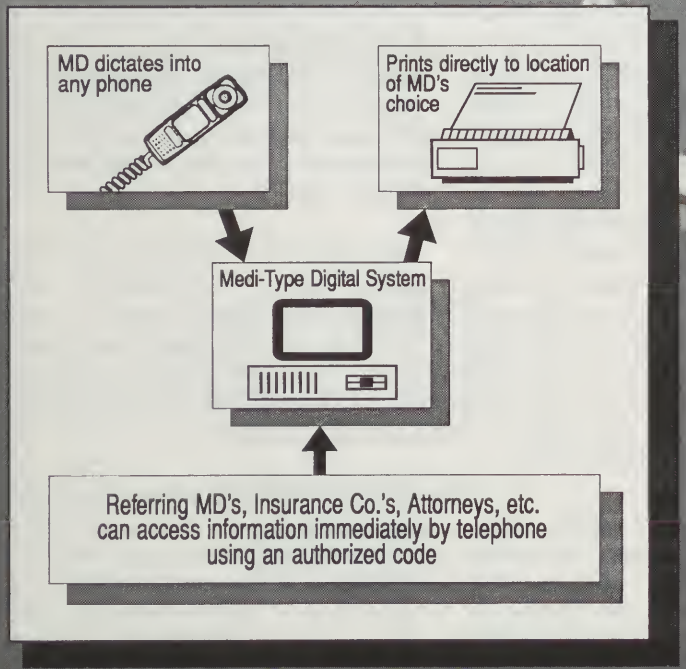


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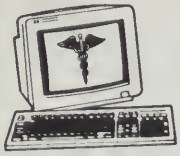
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(ranitidine hydrochloride)

BRIEF SUMMARY

The following is a brief summary only. Before prescribing, see complete prescribing information in Zantac® product labeling.

INDICATIONS AND USAGE: Zantac® is indicated in:
1. Short-term treatment of **active duodenal ulcer**. Most patients heal within 4 weeks.
2. **Maintenance therapy** for duodenal ulcer patients at reduced dosage after healing of acute ulcers.
3. The treatment of **pathological hypersecretory conditions** (e.g., Zollinger-Ellison syndrome and systemic mastocytosis).
4. Short-term treatment of **active, benign gastric ulcer**. Most patients heal within 6 weeks and the usefulness of further treatment has not been demonstrated.
5. Treatment of **gastroesophageal reflux disease (GERD)**. Symptomatic relief commonly occurs within 1 or 2 weeks after starting therapy with Zantac 150 mg b.i.d.
6. Treatment of endoscopically diagnosed **erosive esophagitis**. Healing of endoscopically diagnosed erosive esophagitis occurs at 4 weeks (47%), 8 weeks (71%), and 12 weeks (84%) of therapy with Zantac 150 mg q.i.d. Symptomatic relief of heartburn commonly occurs within 24 hours of therapy initiation with Zantac.

Concomitant antacids should be given as needed for pain relief to patients with active duodenal ulcer; active, benign gastric ulcer; hypersecretory states; GERD; and erosive esophagitis.

CONTRAINDICATIONS: Zantac® is contraindicated for patients known to have hypersensitivity to the drug.

PRECAUTIONS: **General:** 1. Symptomatic response to Zantac® therapy does not preclude the presence of gastric malignancy.
2. Since Zantac is excreted primarily by the kidney, dosage should be adjusted in patients with impaired renal function (see DOSAGE AND ADMINISTRATION). Caution should be observed in patients with hepatic dysfunction since Zantac is metabolized in the liver.
Laboratory Tests: False-positive tests for urine protein with Multistix® may occur during Zantac therapy, and therefore testing with sulfosalicylic acid is recommended.
Drug Interactions: Although Zantac has been reported to bind weakly to cytochrome P-450 *in vitro*, recommended doses of the drug do not inhibit the action of the cytochrome P-450-linked oxygenase enzymes in the liver. However, there have been isolated reports of drug interactions that suggest that Zantac may affect the bioavailability of certain drugs by some mechanism as yet unidentified (e.g., a pH-dependent effect on absorption or a change in volume of distribution).

Increased or decreased prothrombin times have been reported during concurrent use of ranitidine and warfarin. However, in human pharmacokinetic studies with dosages of ranitidine up to 400 mg per day, no interaction occurred; ranitidine had no effect on warfarin clearance or prothrombin time. The possibility of an interaction with warfarin at dosages of ranitidine higher than 400 mg per day has not been investigated.
Carcinogenesis, Mutagenesis, Impairment of Fertility: There was no indication of tumorigenic or carcinogenic effects in life-span studies in mice and rats at dosages up to 2,000 mg/kg per day.

Ranitidine was not mutagenic in standard bacterial tests (*Salmonella, Escherichia coli*) for mutagenicity at concentrations up to the maximum recommended for these assays.

In a dominant lethal assay, a single oral dose of 1,000 mg/kg to male rats was without effect on the outcome of two matings per week for the next 9 weeks.
Pregnancy: ***Teratogenic Effects: Pregnancy Category B***: Reproduction studies have been performed in rats and rabbits at doses up to 160 times the human dose and have revealed no evidence of impaired fertility or harm to the fetus due to Zantac. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.
Nursing Mothers: Zantac is secreted in human milk. Caution should be exercised when Zantac is administered to a nursing mother.
Pediatric Use: Safety and effectiveness in children have not been established.
Use in Elderly Patients: Ulcer healing rates in elderly patients (65-82 years of age) were no different from those in younger age-groups. The incidence rates for adverse events and laboratory abnormalities were also not different from those seen in other age-groups.

ADVERSE REACTIONS: The following have been reported as events in clinical trials or in the routine management of patients treated with Zantac®. The relationship to Zantac therapy has been unclear in many cases. Headache, sometimes severe, seems to be related to Zantac administration.
Central Nervous System: Rarely, malaise, dizziness, somnolence, insomnia, and vertigo. Rare cases of reversible mental confusion, agitation, depression, and hallucinations have been reported, predominantly in severely ill elderly patients. Rare cases of reversible blurred vision suggestive of a change in accommodation have been reported. Rare reports of reversible involuntary motor disturbances have been received.
Cardiovascular: As with other H_2-blockers, rare reports of arrhythmias such as tachycardia, bradycardia, atrioventricular block, and premature ventricular beats.
Gastrointestinal: Constipation, diarrhea, nausea/vomiting, abdominal discomfort/pain, and rare reports of pancreatitis.
Hepatic: In normal volunteers, SGPT values were increased to at least twice the pretreatment levels in 6 of 12 subjects receiving 100 mg q.i.d. intravenously for 7 days, and in 4 of 24 subjects receiving 50 mg q.i.d. intravenously for 5 days. There have been occasional reports of hepatitis, hepatocellular or hepatocanalicular or mixed, with or without jaundice. In such circumstances, ranitidine should be immediately discontinued. These events are usually reversible, but in exceedingly rare circumstances death has occurred.
Musculoskeletal: Rare reports of arthralgias.
Hematologic: Blood count changes (leukopenia, granulocytopenia, and thrombocytopenia) have occurred in a few patients. These were usually reversible. Rare cases of agranulocytosis, pancytopenia, sometimes with marrow hypoplasia, and aplastic anemia and exceedingly rare cases of acquired immune hemolytic anemia have been reported.
Endocrine: Controlled studies in animals and man have shown no stimulation of any pituitary hormone by Zantac and no antiandrogenic activity, and cimetidine-induced gynecomastia and impotence in hypersecretory patients have resolved when Zantac has been substituted. However, occasional cases of gynecomastia, impotence, and loss of libido have been reported in male patients receiving Zantac, but the incidence did not differ from that in the general population.
Integumentary: Rash, including rare cases suggestive of mild erythema multiforme, and, rarely, alopecia.
Other: Rare cases of hypersensitivity reactions (e.g., bronchospasm, fever, rash, eosinophilia), anaphylaxis, angioneurotic edema, and small increases in serum creatinine.

OVERDOSAGE: Information concerning possible overdosage and its treatment appears in the full prescribing information.

DOSAGE AND ADMINISTRATION: (See complete prescribing information in Zantac® product labeling.)
Active Duodenal Ulcer. The current recommended adult oral dosage is 150 mg or 10 mL (2 teaspoonfuls equivalent to 150 mg of ranitidine) twice daily. An alternative dosage of 300 mg or 20 mL (4 teaspoonfuls equivalent to 300 mg of ranitidine) once daily at bedtime can be used for patients in whom dosing convenience is important. The advantages of one treatment regimen compared to the other in a particular patient population have yet to be demonstrated.
Maintenance Therapy: The current recommended adult oral dosage is 150 mg or 10 mL (2 teaspoonfuls equivalent to 150 mg of ranitidine) at bedtime.
Pathological Hypersecretory Conditions (such as Zollinger-Ellison syndrome): The current recommended adult oral dosage is 150 mg or 10 mL (2 teaspoonfuls equivalent to 150 mg of ranitidine) twice a day. In some patients it may be necessary to administer Zantac® 150-mg doses more frequently. Dosages should be adjusted to individual patient needs, and should continue as long as clinically indicated. Dosages up to 6 g per day have been employed in patients with severe disease.
Benign Gastric Ulcer: The current recommended adult oral dosage is 150 mg or 10 mL (2 teaspoonfuls equivalent to 150 mg of ranitidine) twice a day.
GERD: The current recommended adult oral dosage is 150 mg or 10 mL (2 teaspoonfuls equivalent to 150 mg of ranitidine) twice a day.
Erosive Esophagitis: The current recommended adult oral dosage is 150 mg or 10 mL (2 teaspoonfuls equivalent to 150 mg of ranitidine) four times a day.
Dosage Adjustment for Patients With Impaired Renal Function: On the basis of experience with a group of subjects with severely impaired renal function treated with Zantac, the recommended dosage in patients with a creatinine clearance less than 50 mL per minute is 150 mg or 10 mL (2 teaspoonfuls equivalent to 150 mg of ranitidine) every 24 hours. Should the patient's condition require, the frequency of dosing may be increased to every 12 hours or even further with caution. Hemodialysis reduces the level of circulating ranitidine. Ideally, the dosing schedule should be adjusted so that the timing of a scheduled dose coincides with the end of hemodialysis.

HOW SUPPLIED: **Zantac® 150 Tablets** (ranitidine HCl equivalent to 150 mg of ranitidine) are peach, film-coated, five-sided tablets embossed with "ZANTAC 150" on one side and "Glaxo" on the other. They are available in bottles of 60 (NDC 0173-0344-42) and 100 (NDC 0173-0344-09) tablets and unit dose packs of 100 (NDC 0173-0344-47) tablets.

Zantac® 300 Tablets (ranitidine HCl equivalent to 300 mg of ranitidine) are yellow, film-coated, capsule-shaped tablets embossed with "ZANTAC 300" on one side and "Glaxo" on the other. They are available in bottles of 30 (NDC 0173-0393-40) tablets and unit dose packs of 100 (NDC 0173-0393-47) tablets.

Store between 15° and 30°C (59° and 86°F) in a dry place. Protect from light. Replace cap securely after each opening.

Zantac® Syrup, a clear, peppermint-flavored liquid, contains 16.8 mg of ranitidine HCl equivalent to 15 mg of ranitidine per 1 mL in bottles of 16 fluid ounces (one pint) (NDC 0173-0383-54).

Store between 4° and 25°C (39° and 77°F). Dispense in tight, light-resistant containers as defined in the USP/NF.

May 1992
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Glaxo Pharmaceuticals
DIVISION OF GLAXO INC.

Zantac® 150 Tablets/Zantac® 300 Tablets:
Glaxo Pharmaceuticals, Research Triangle Park, NC 27709

Zantac® Syrup:
Manufactured for Glaxo Pharmaceuticals, Research Triangle Park, NC 27709
by Roxane Laboratories, Inc., Columbus, OH 43216

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One Of A Kind



Zantac®

ranitidine HCl/Glaxo 150 mg and 300 mg tablets

Please see Brief Summary of Prescribing Information on adjacent page.

Glaxo/ ROCHE